Patient Information

Midland Physical Therapy

Name: ____________________ Date of Birth: __________ Age: ______
Mailing Address: ____________________ City: __________ State: ______ Zip Code: ______
Social Security: ____________________ Sex: _____M _____F Telephone: __________
Employer: ____________________ Address: ____________________ Telephone: __________
City: ____________________ State: __________ Zip Code: __________
Email Address: ____

Emergency Contact

Name: ____________________ Relation to patient: __________ Telephone: __________
Address: ____________________ City: __________ State: ______ Zip Code: ______
Please list the names of family members or significant others, if any, whom we may inform of your medical condition and diagnosis in case of an emergency:
Name: ____________________ Telephone: ____________________
Name: ____________________ Telephone: ____________________

Responsible Party (if other than the patient)

Name: ____________________ Date of Birth: __________ Relation to patient: __________
Social Security: ____________________ Telephone: ____________________
Address: ____________________ City: __________ State: ______ Zip Code: ______
Employer: ____________________ Occupation: ____________________ Telephone: __________
Address: ____________________ City: __________ State: ______ Zip Code: ______

Insurance ☐ **Commercial** ☐ **Worker's Comp - Date of Injury:** __________ ☐ **Medicare**

Insurance Company: ____________________ Telephone: ____________________
Insured's Name: ____________________ Date of Birth: ____________________
Policy #: ____________________ Group #: ____________________
Name of Adjustor: ____________________ Telephone: ____________________
Secondary Insurance: ____________________ Telephone: ____________________
Insured's Name: ____________________ Date of Birth: ____________________
Policy #: ____________________ Group #: ____________________

I certify that the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by the insurance. I also understand that it is my responsibility to inform **MIDLAND PHYSICAL THERAPY, PC** of any changes regarding my personal or insurance information. A copy of the Patient Policies has been given to me and I understand that it is expected of me to follow these policies as stated unless a written agreement stating otherwise is in my chart.

____ Date: ____________________
Patient/Guardian Signature

Medical Information: **Midland Physical Therapy**

Who referred you to our clinic? ____Friend/Relative ____Physician ______Other: __________________

Referring Physician:_____________________________ Next Appointment:_______________________

Name of person who referred you to our clinic:____

Have you ever been a patient of ours in the past? _____Yes _____No If so, when? _________________

Are we seeing you for the same injury/diagnosis? _____Yes _____No

What is your current medical ailment? ____

Date of injury/ailment first occurred? ____

If you were injured, describe how the injury occurred: ____

____

Did this injury happen on the job? ______ Yes ______ No

Were you injured in an auto accident? _______ Yes _______ No If so, Date of accident _____________

Do you have an attorney? ______ Yes ______ No Name: ____________________________________

Previous Treatment:

Previous Treatment: _____Medical Doctor _____ Physical Therapy ______ Chiropractor ______ Other

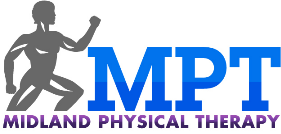
Have you had: _____ X-rays _____ MRI _____ CAT Scan _____ EMG _____Nerve Velocity

Approximate dates: ________________ Results: ____

Please check any current or previous conditions:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart problems
- ☐ Pacemaker
- ☐ Seizures
- ☐ Cancer: _____________
- ☐ Tumors
- ☐ Rheumatoid Disease
- ☐ Metal/Hardware Implants
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Pregnant

Patient/Guardian Signature:__________________________________ Date: ________________________



Cindy Greenfield, PT
Katy Blonkvist, PT
Jimmy Guzman, PTA
AnnStavinoha, PTA

Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Midland Physical Therapy & Sports Rehabilitation, PC creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that the Notice of Privacy Practices provides a more complete description of the users and disclosures of certain health information. I have been provided the opportunity to read this Notice of Privacy Practices of Midland Physical Therapy and Sports Rehabilitation, PC. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations (quality assessment and improvement activities, underwriting premiums rating, conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

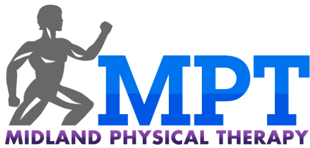
This consent is given freely with the understanding that,

1. Any and all records, whether written or oral or in electronic format, are confidential cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization.

2. A photocopy or fax of this consent is valid as this original.

3. I have the right to request that the used of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment of health care operations be restricted. I also understand the practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information, and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________	________________________
Patients Printed Name	Date
______________________________	________________________
Patient/Guardian Signature	Social Security Number
______________________________	________________________
Witness (Optional)	Date



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Authorization for Treatment

I herby request and authorize treatment from Midland Physical Therapy and Sports Rehabilitation, PC and associates or assistants of its choice.

Authorization to Release Information

Midland Physical Therapy and Sports Rehabilitation, PC may disclose all or part of this patient's records to any insurance company or association or the Federal or State Government as such information may deemed necessary for the completion of all clinic claims.

Assignment of Benefits

I hereby authorize payment to Midland Physical Therapy and Sports Rehabilitation, PC for benefits specified and otherwise payable to me for any services rendered by the clinic subsequent in this date and for such other charges as may be made by said clinic. I understand that any remaining balance will be my responsibility.

If I am covered under the Medicare plan I certify that the information given by me applying under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information necessary for this or related medical claim. I request that payments of Authorized Benefits made on or in my behalf to Midland Physical Therapy and Sports Rehabilitation and a copy shall be as valid as the original.

I, the undersigned, certify that I have read the foregoing, and am the patient or duly authorize by the patient, as the patients general agent, to execute the above and accept its terms.

____ I am currently receiving Home Health Services (Example: Nurses are coming into my home). These services are provided by ___________________________________ Home Health Company.

____ I am not receiving Home Health Services at this time.

Have you received any physical therapy, occupational therapy or speech therapy this year? _____ Yes _____No

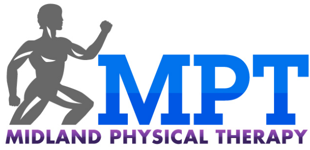
If yes, where: ____

____ _______________________________________

Name of Patient (Print) Date

____ _______________________________________

Signature Witness (Not related to patient)



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ATTENDANCE

The Texas Workers Compensation Commission (TWCC) requires that patients follow the frequency and duration per doctor's order or physical therapist recommendations.

Our office will notify your WC Company/Adjustor of all visits that are missed. This will include no-show and cancelled appointments.

We do understand that there are occasional instances when you cannot attend your scheduled appointment, however, it is your responsibility to contact your adjustor to inform them of the reason for your absence.

Adjustor Name: ________________________________ Phone#: ___________________

Please be aware that TTWCC can at any time cut your benefits if you are not compliant with your physical therapy.

By signing below, I acknowledge that I am aware of the importance of my attendance to my physical therapy visits.

Patient Signature: ____________________________ Date:________________________

Witness: _____________________________________ Date: _______________________