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
- ☐ COPD/Emphysema
- ☐ Tuberculosis
- ☐ Recent gain/loss of weight
- ☐ Constant night pain
- ☐ Night sweats
- ☐ Loss of bowel or bladder function
- ☐ Pregnant
- ☐ Joint replacements
- ☐ Fractures: ______
- ☐ Fever
- ☐ AIDS or HIV
- ☐ Hepatitis A, B, or C

Patient/Guardian Signature: ______ Date: ______

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

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)

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: _____________________

REQUEST FOR CONFIDENTIAL COMMUNICATIONS
&
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Name of Patient: ______________________________
(Please print)
Date of Birth: ______________________________

I have been presented with a copy of the Privacy Notice Form, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I request that all communications to me (by telephone, mail, electronic mail or otherwise) by Midland Physical Therapy and staff are handled as follows:

- For WRITTEN Communication Address to:

Name: ______________________________
Address: ______________________________
City and State: ______________________________

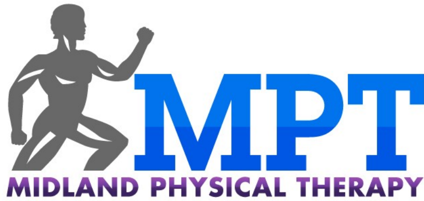
- For ORAL Communication Call:
  - Home: ______________ May we leave a message? Yes ☐ No ☐
  - Work: ______________ May we leave a message? Yes ☐ No ☐
  - Cell: ______________ May we leave a message? Yes ☐ No ☐
- For APPOINTMENT REMINDERS (please choose one):
  - TEXT: ______________
  - PHONE CALL: ______________
  - EMAIL: ______________
- ELECTRONIC MAIL Communication to E-mail Address: ______________

- If the address above is not your home address OR is not a street address, please provide us with a street address for purposes of ensuring payment:

____
____

- I wish to place the following restrictions on disclosure of my health information:
  ____

Patient (Guardian) Signature: ______________ Date: ______________
Relationship to Patient: ______________



MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask of you.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

With the exception of a serious emergencies, it is expected that you keep all of your appointments. If you need to cancel an appointment we require a 24 hour notice. In such a case, please call our office and speak with our receptionist to arrange a make-up appointment. The make-up appointment needs to be in the same week, preferably the very next day.

We reserve the right to charge you a $50.00 fee for all appointments not canceled with a 24 hour notice or no-show appointments.

We also reserve the right to discontinue care for repeated non-compliance. We will inform your physician that your services have been discontinued due to non-compliance.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Cindy Greenfield, PT
Midland Physical Therapy, PC

I have read and understand this policy: ______________________________ Date: __________