Patients Name: ______________________ Date: ____________

Patient Information Form

IMPORTANT! Items in **BOLD** are required to process your claims. Failure to provide this information could lead to the denial of benefits.

Last Name: ____________ **First Name:** ____________ MI: ______

Address: ______________________ **Sex:** M☐ F☐

City: ________ **State:** ______ **Zip:** ______ **Email:** ____________

Social Security #: ____________ **Date of Birth:** ____________

Home Phone: ____________ **Cell Phone:** ____________

Work related: Yes ☐ No ☐ **If Yes, date of Injury?** ____________

*If work related, the following information **MUST** be completed to process your claim.

Employer: ____________ Drivers License #: ____________

Address: ______________________

City: ________ **State:** ______ **Zip:** ______ **Work Phone:** ____________

In case of emergency notify: ____________ **Phone:** ____________

I understand that I am responsible for all charges incurred by me and all charges not allowed by my insurance company. I authorize release of any medical information necessary to process my claims. I authorize payment of any assigned benefits to Back To Action.

Signature: **Date:**

Office Use Only

REFERRING PHYSICIAN: ____________ **NPI #:** ____________

DIAGNOSIS: ______________________

Photo Release

I agree to allow Back to Action Physical Therapy to use pictures taken of me for medical purposes only. Pictures will be seen by the referring physician, his staff and our staff only.

______________________ ____________

Signature Date

Patients Name: ______________________________ Date: ______________

Conditions & Informed Consent for Physical Therapy

I understand that I am a patient of Back To Action, a private, therapist owned Physical Therapy practice.

Cooperation with Treatment In order for Physical Therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. If I have trouble with any part of my treatment program, I will discuss it with my Physical Therapist.

Cancellation Policy I understand that to successfully achieve the goals of treatment established by myself and my physical therapist it is essential for consistent attendance as outlined by my plan of care. I understand that three (3) no shows could result in my discharge from therapy. Furthermore, I understand that if I cancel more than 12 hours in advance I will not be charged. I understand that if I cancel in less than 12 hours in advance I will pay a cancellation fee of $25.00.

Limitations I understand that there are no guarantees regarding a cure for, or improvement in my condition. I understand that my Physical Therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. There may be times where my insurance company will withhold payment for certain services rendered but care will be taken to inform me of such circumstances prior to rendered services.

Informed Consent for Treatment I understand the term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential Risks I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential Benefits I understand I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I can expect to gain a greater knowledge about managing my condition and the resources available to me.

Alternatives I understand that if I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

Financial and Insurance Responsibilities I understand that my insurance is a contract between myself or my employer and the insurance company. And that Back To Action is not a party to that contract. I understand that Back To Action will call my insurance carrier as a courtesy for me but ultimately it is my responsibility to verify the information Back To Action receives is accurate. If I have any questions regarding my insurance coverage I understand that I can ask my insurance carrier, my therapist, or Back To Action for further assistance.

Notice of Privacy Policies I understand that I was provided with a copy of the Notice of Privacy Policies utilized by Back To Action in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) Sec.45 CFR 160 and 164. I understand that if I would like more information about Back To Action Physical Therapy privacy practices or to file a complaint I can contact Back To Action attn: privacy Officer at 1801 N. Ed carey Dr. Harlingen TX 78550.

I have read the above information and I consent to the Physical Therapy Evaluation and all subsequent treatment.

______________________________ ______________________________

Print Name Date

Patients Name: ______________________ Date: ____________

______________________ ______________________

Patient/Parent(guardian) Signature if patient is under 18 years of age   Witness

Health History Form

Reason for Current Visit: ______________________

SYMPTOMS Check (x) symptoms you currently have.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of balance
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nausea
- ☐ Nervousness
- ☐ Numbness
- ☐ Ringing in ears
- ☐ Sweats

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful Urination

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Sore that won't heal

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

- ☐ Jaw
- ☐ Neck
- ☐ Shoulder R/L
- ☐ Arm R/L
- ☐ Elbow R/L
- ☐ Wrist R/L
- ☐ Hand R/L
- ☐ Back
- ☐ Hip R/L
- ☐ Leg R/L
- ☐ Knee R/L
- ☐ Ankle R/L
- ☐ Foot R/L

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bowel changes
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

MEDICATIONS List medications you are currently taking.

HOSPITALIZATIONS/SURGERIES

Year	Reason for Hospitalization and Outcome

SERIOUS ILLNESS/INJURIES

Year	Description and Outcome

MISC/OTHER

CONDITIONS Check (x) conditions you have or have had in the past.

☐ Aids/HIV	☐ Chemical Dependency	☐ High Cholesterol	☐ Rheumatic fever
☐ Alchoholism	☐ Chicken Pox	☐ Kidney Disease	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Liver Disease	☐ Seizures
☐ Anorexia	☐ Emphysema	☐ Measles/Mumps	☐ Stroke
☐ Appendicitis	☐ Epilepsy	☐ Migraine Headaches	☐ Suicide Attempt
☐ Arthritis	☐ Fibromyalgia	☐ Miscarraige	☐ TMJ
☐ Asthma	☐ Glaucoma	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Goiter	☐ Osteoporosis	☐ Tuberculosis
☐ Bronchitis	☐ Gout	☐ Pacemaker	☐ Ulcers
☐ Bulemia	☐ Heart Disease	☐ Polio	☐ Venereal Disease
☐ Cancer	☐ Hepatitis	☐ Prostate Problem	☐ Other____________
☐ Cataracts	☐ Hernia	☐ Psychiatric Care	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my health care professional if I, or my minor child, ever have a change in health.

______________________ ____________

Signature of Patient, Parent, Guardian or Personal representative   Date

Patients Name: ______________________ Date: ______________

A. Notifier: **C. Identification Number**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. **below.**

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy if you are receiving home health	**That is their rule**	**100$ per visit**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

OPTION 1. I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

OPTION 3. I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.