New Patient Registration Form (Adult)

Today's Date_______________________

Patient Information: Name____Age______________

SSN#________________________D.O.B. __________________Sex (circle one) M F Marital Status___________

Address_______________________________City________________________State_______Zip__________

Home Phone _________________ Cell Phone ___________________ Email ______________________________

Employer ____ Work Phone_______________

Employer's Address________________________________City____________State________Zip__________

Responsible Party: Name: ____
Relation to Patient □ Spouse □ Parent □ Guardian

DOB: ___________________ SSN# ______________________________

Address ____ Home Phone ______________
Street City State Zip

Employer____ Cell Phone ____________________

Employer's Address ____Work Phone _______________
Street City State Zip

Primary Insurance Name:____

Address ________________________________City, State, Zip _______________________________________

Policy #_____________________________________ Group # __________________________

Policy Holder Name ____

DOB:______________ SSN#_____________________________________Cell Phone______________________

Employer____ Work Phone__________________

Employer's Address ____
Street City State Zip

Secondary Insurance Name: ____

Address_________________________________ City, State, Zip ______________________________________

Policy # ____________________________________ Group # _______________________________________

Policy Holder Name ____D.O.B._____________________________

Misc.
Info.____

By signing, I attest that all information provided is true and complete and that my injury/illness is not work related. I authorize the release of any necessary medical information and payment of medical benefits to the physician for services rendered. I understand and agree that:

1) I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the notice;
2) I am fully responsible for all charges to me including the balance remaining after payment of insurance benefits (as per your insurance contract);
3) Payment is expected on the day services are rendered unless prior arrangements are made; **** Your copay is __________.****

Patient or Responsible Party Signature: ______________________________________ Date __________

Patient Consent Form

I hereby consent to rehabilitation treatment as prescribed by my physician, or as deemed necessary by the treating therapist.

The patient is responsible for charges incurred, regardless of insurance coverage. If we have a contract with your insurance carrier, we will file the claim for your services. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I am responsible for all balances due.

Centex Rehabilitation, LLC Accepts assignment for Medicare patients.

I understand, in some instances, the applicable rehabilitation charges billed to my insurance company may not be covered under my insurance policy. I agree to be responsible for any portion of my bill not covered by insurance**. I understand it is my responsibility for checking on my insurance benefits and complying with the requirements of the policy.**

I have read and understand the above statements.

____ __________________________

Signature of Patient or Parent/Guardian Date

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- I have been informed by you of your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Centex Rehabilitation has the right to change its Notice of Privacy Practices from time to time and that I may contact Centex Rehabilitation at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Patient Signature: ____

Date: ____

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Outpatient Form 1, Page 1

Today's Date: ____________
Patient ID#: ____________

American Physical Therapy Association

1 Name:

a Last ____________

b First ____________ c MI ______ d Jr/Sr ______

2 Street Address: ____________

City ____________ State ______ Zip ______

3 Date of Birth: Month ☐☐ Day ☐☐ Year ☐☐☐☐

4 Sex: a ☐ Male b ☐ Female

5 Are you: a ☐ Right-handed b ☐ Left-handed

6 Type of Insurance: a ☐ Insurer ____________
b ☐ Workers' Comp c ☐ Medicare d ☐ Self-pay e ☐ Other

7 Race:
- a ☐ American Indian or Alaska Native
- b ☐ Asian
- c ☐ Black or African American
- d ☐ Hispanic or Latino
- e ☐ Native Hawaiian or Other Pacific Islander
- f ☐ White

8 Ethnicity:
- a ☐ Hispanic or Latino
- b ☐ Not Hispanic or Latino

9 Language:
- a ☐ English understood
- b ☐ Interpreter needed
- c ☐ Language you speak most often: ____________

10 Education:
- a Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
- b ☐ Some college / technical school
- c ☐ College graduate
- d ☐ Graduate school / advanced degree

SOCIAL HISTORY

11 Cultural/Religious: Any customs or religious beliefs or wishes that might affect care?
____

12 With whom do you live:
- a ☐ Alone
- b ☐ Spouse only
- c ☐ Spouse and other(s)
- d ☐ Child (not spouse)
- e ☐ Other relative(s) (not spouse or children)
- f ☐ Group setting
- g ☐ Personal care attendant
- h ☐ Other:

13 Have you completed an advance directive? a ☐ Yes b ☐ No

14 Who referred you to the physical therapist:
____

15 Employment/Work (Job/School/Play)
- a ☐ Working full-time outside of home
- b ☐ Working part-time outside of home
- c ☐ Working full-time from home
- d ☐ Working part-time from home
- e ☐ Homemaker
- f ☐ Student
- g ☐ Retired
- h ☐ Unemployed
- i Occupation: ____________

LIVING ENVIRONMENT

16 Does your home have:
- a ☐ Stairs, no railing
- b ☐ Stairs, railing
- c ☐ Ramps
- d ☐ Elevator
- e ☐ Uneven terrain
- f ☐ Assistive devices (eg, bathroom): ________
- g ☐ Any obstacles: ____________

17 Do you use:
- a ☐ Cane
- b ☐ Walker or rollator
- c ☐ Manual wheelchair
- d ☐ Motorized wheelchair
- e ☐ Glasses, hearing aids
- f ☐ Other: ____________

18 Where do you live:
- a ☐ Private home
- b ☐ Private apartment
- c ☐ Rented room
- d ☐ Board and care / assisted living / group home
- e ☐ Homeless (with or without shelter)
- f ☐ Long-term care facility (nursing home)
- g ☐ Hospice
- h ☐ Other: ____________

19 GENERAL HEALTH STATUS

a Please rate your health:
(1) ☐ Excellent (2) ☐ Good (3) ☐ Fair (4) ☐ Poor

b Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) (1) ☐ Yes (2) ☐ No

20 SOCIAL/HEALTH HABITS

a Smoking
(1) Currently smoke tobacco? (a) ☐ Yes 1. ☐ Cigarettes: # of packs per day __
2. ☐ Cigars/Pipes: # per day __
(b) ☐ No

(2) Smoked in past? (a) ☐ Yes Year quit: ☐☐☐☐ (b) ☐ No

b Alcohol
(1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? ___
(2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? ___

c Exercise
Do you exercise beyond normal daily activities and chores?
(a) ☐ Yes Describe the exercise: ____________
1. On average, how many days per week do you exercise or do physical activity? _______
2. For how many minutes, on an average day? ____
(b) ☐ No

21 FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)
- a Heart disease: ____________
- b Hypertension: ____________
- c Stroke: ____________
- d Diabetes: ____________
- e Cancer: ____________
- f Psychological: ____________
- g Arthritis: ____________
- h Osteoporosis: ____________
- i Other: ____________

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22 MEDICAL/SURGICAL HISTORY

a Please check if you have ever had:

- (1) ☐ Arthritis
- (2) ☐ Broken bones/fractures
- (3) ☐ Osteoporosis
- (4) ☐ Blood disorders
- (5) ☐ Circulation/vascular problems
- (6) ☐ Heart problems
- (7) ☐ High blood pressure
- (8) ☐ Lung problems
- (9) ☐ Stroke
- (10) ☐ Diabetes/high blood sugar
- (11) ☐ Low blood sugar/hypoglycemia
- (12) ☐ Head injury
- (13) ☐ Multiple sclerosis
- (14) ☐ Muscular dystrophy
- (15) ☐ Parkinson disease
- (16) ☐ Seizures/epilepsy
- (17) ☐ Allergies
- (18) ☐ Developmental or growth problems
- (19) ☐ Thyroid problems
- (20) ☐ Cancer
- (21) ☐ Infectious disease (eg, tuberculosis, hepatitis)
- (22) ☐ Kidney problems
- (23) ☐ Repeated infections
- (24) ☐ Ulcers/stomach problems
- (25) ☐ Skin diseases
- (26) ☐ Depression
- (27) ☐ Other:________________

b Within the past year, have you had any of the following symptoms? (Check all that apply)

- (1) ☐ Chest pain
- (2) ☐ Heart palpitations
- (3) ☐ Cough
- (4) ☐ Hoarseness
- (5) ☐ Shortness of breath
- (6) ☐ Dizziness or blackouts
- (7) ☐ Coordination problems
- (8) ☐ Weakness in arms or legs
- (9) ☐ Loss of balance
- (10) ☐ Difficulty walking
- (11) ☐ Joint pain or swelling
- (12) ☐ Pain at night
- (13) ☐ Difficulty sleeping
- (14) ☐ Loss of appetite
- (15) ☐ Nausea/vomiting
- (16) ☐ Difficulty swallowing
- (17) ☐ Bowel problems
- (18) ☐ Weight loss/gain
- (19) ☐ Urinary problems
- (20) ☐ Fever/chills/sweats
- (21) ☐ Headaches
- (22) ☐ Hearing problems
- (23) ☐ Vision problems
- (24) ☐ Other:________________

c Have you ever had surgery? (1) ☐ Yes (2) ☐ No
If yes, please describe, and include dates:

	Month	Year
________________________	☐☐	☐☐☐☐
________________________	☐☐	☐☐☐☐
________________________	☐☐	☐☐☐☐

For men only: d Have you been diagnosed with prostate disease?
(1) ☐ Yes (2) ☐ No

For women only:
Have you been diagnosed with:

e Pelvic inflammatory disease?
(1) ☐ Yes (2) ☐ No

f Endometriosis?
(1) ☐ Yes (2) ☐ No

g Trouble with your period?
(1) ☐ Yes (2) ☐ No

h Complicated pregnancies or deliveries?
(1) ☐ Yes (2) ☐ No

i Pregnant, or think you might be pregnant?
(1) ☐ Yes (2) ☐ No

j Other gynecological or obstetrical difficulties?
(1) ☐ Yes (2) ☐ No
If yes, please desribe:________

23 CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

a Describe the problem(s) for which you seek physical therapy:
____
____

b When did the problem(s) begin (date)? Month ☐☐ Year ☐☐☐☐

c What happened? ________________________
____

d Have you ever had the problem(s) before?
(1) ☐ Yes
(a) What did you do for the problem(s)? ______________
____
(b) Did the problem(s) get better?
1. ☐ Yes 2. ☐ No
(c) About how long did the problem(s) last?______________
(2) ☐ No

23 Current Condition(s)/Chief Complaint(s) (continued)

e How are you taking care of the problem(s) now? ______________
____

f What makes the problem(s) better? ______________
____

g What makes the problem(s) worse? ______________
____
____

h What are your goals for physical therapy? ______________
____

i Are you seeing anyone else for the problem(s)? (Check all that apply)

- (1) ☐ Acupuncturist
- (2) ☐ Cardiologist
- (3) ☐ Chiropractor
- (4) ☐ Dentist
- (5) ☐ Family practitioner
- (6) ☐ Internist
- (7) ☐ Massage therapist
- (8) ☐ Neurologist
- (9) ☐ Obstetrician/gynecologist
- (10) ☐ Occupational therapist
- (11) ☐ Orthopedist
- (12) ☐ Osteopath
- (13) ☐ Pediatrician
- (14) ☐ Podiatrist
- (15) ☐ Primary care physician
- (16) ☐ Rheumatologist
- Other:____________________

24 FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply):

a ☐ Difficulty with locomotion/movement:
- (1) ☐ bed mobility
- (2) ☐ transfers (such as moving from bed to chair, from bed to commode)
- (3) ☐ gait (walking)
  - (a) ☐ on level
  - (b) ☐ on stairs
  - (c) ☐ on ramps
  - (d) ☐ on uneven terrain

b ☐ Difficulty with self-care (such as bathing, dressing, eating, toileting)

c ☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

d ☐ Difficulty with community and work activities/integration
- (1) ☐ work/school
- (2) ☐ recreation or play activity

25 MEDICATIONS

a Do you take any prescription medications? (1) ☐ Yes (2) ☐ No
If yes, please list: ________________________
____

b Do you take any nonprescription medications? (Check all that apply)

- (1) ☐ Advil/Aleve
- (2) ☐ Antacids
- (3) ☐ Ibuprofen/Naproxen
- (4) ☐ Antihistamines
- (5) ☐ Aspirin
- (6) ☐ Decongestants
- (7) ☐ Herbal supplements
- (8) ☐ Tylenol
- (9) ☐ Other: ______________
____
____

c Have you taken any medications previously for the condition for which you are seeing the physical therapist?
(1) ☐ Yes (2) ☐ No If yes, please list:____________________
____

26 OTHER CLINICAL TESTS—Within the past year, have you had any of the following tests? (Check all that apply)

- a ☐ Angiogram
- b ☐ Arthroscopy
- c ☐ Biopsy
- d ☐ Blood tests
- e ☐ Bone scan
- f ☐ Bronchoscopy
- g ☐ CT scan
- h ☐ Doppler ultrasound
- i ☐ Echocardiogram
- j ☐ EEG (electroencephalogram)
- k ☐ EKG (electrocardiogram)
- l ☐ EMG (electromyogram)
- m ☐ Mammogram
- n ☐ MRI
- o ☐ Myelogram
- p ☐ NCV (nerve conduction velocity)
- q ☐ Pap smear
- r ☐ Pulmonary function test
- s ☐ Spinal tap
- t ☐ Stool tests
- u ☐ Stress test (eg, treadmill, bicycle)
- v ☐ Urine tests
- x ☐ X-rays
- y ☐ Other:________________

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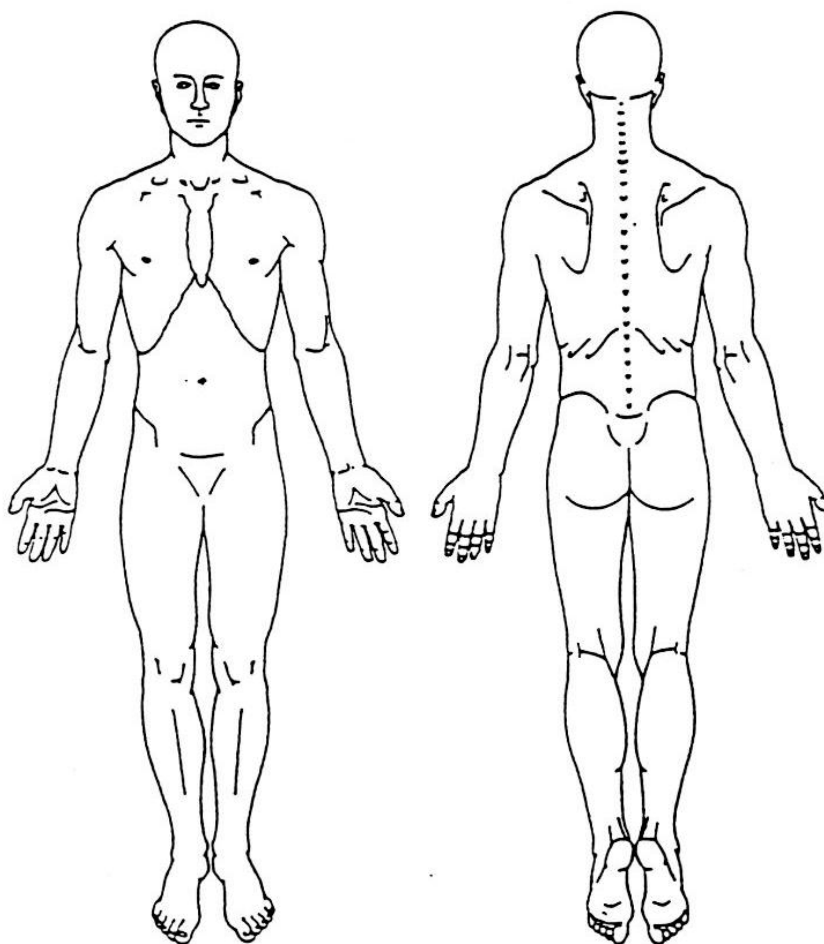
PAIN DIAGRAM

On the body diagram below, please indicate where your pain is located at present time. Please do not indicate areas of pain that are not related to your present injury of condition.

+++ Dull	/ / / Sharp	OOO Numbness	- - - Burning



PAIN SCALE
Please rate the severity of your pain:

0 No Pain	1	2 Mild	3	4 Moderate	5	6 Severe	7	8 Very Severe	9	10 Worst Possible

Current Pain Level: ______

Best Pain Level: ______ Worst Pain Level: _____

Clinic Policies

We strive to provide you with the very best personalized care available. To make this possible we adhere to an important set of policies. Please read them over carefully and indicate your agreement by signing at the bottom.

Cancellations ($25 fee without 24 hour notice):
If you wish to cancel or reschedule an appointment please call us at 254-630-1186 with at least 24 hour advance notice. Advance notice allows someone else (who needs it) access to that appointment time. Thank you in advance for being courteous and responsible.

Failing to Show ($25 fee):
If you fail to show for an appointment without notice, your account will be billed $25 and all future appointments you have scheduled will be removed. You may reschedule these appointments again on a "first come, first serve basis".

Tardiness:
If you are more than 10 minutes late to your appointment you will be asked to reschedule as it interferes with the next patient's appointment. Understand that your appointment time is saved specifically for you and if you are late you affect your therapy, as well as negatively affecting other patients who arrive promptly.

Returned Checks & Delinquent Accounts:
In the event we have a check returned, a $25.00 returned check fee will be applied to your account. All accounts that become delinquent and that are forwarded to a collection agency will be charged a fee of 30% of the balance.

Family and Guests in Clinic:
One family member may accompany you in the clinic. We reserve the right to refuse guest in the clinic area. Brothers and sisters of patients are not allowed into the treatment area.

Children in Clinic:
One child may accompany you in the clinic but needs to be supervised and must stay off clinic equipment. We reserve the right to end the treatment session should the child become disruptive to your treatment and to others. By signing below, you acknowledge and agree that neither Centex Rehabilitation, nor any of its members, employees or representatives, shall have any responsibility to supervise your children in the clinic, and you agree to release for yourself and

your children, Centex Rehabilitation and its members, employees or representatives from any and all claims of any kind that you or your children may have against any of them at any time hereafter as a result of your children's presence in the clinic or anything arising in connection therewith. Thank you for your understanding and cooperation.

Parents are required to remain on the premises at all times for children who are receiving treatment at Centex Rehabilitation.

Insurance:
We may attempt to verify your insurance benefits as a courtesy to you. However, we strongly encourage you to know your benefits for physical and occupational therapy. Please be aware that you are ultimately responsible for payment.

Cell Phones:
If you must have your cell phone on for emergency purposes only, please put it on vibrate and keep calls to a minimum. Both your time and the therapist's time is important. Please respect this by holding off on calls until your therapy is over.

Participation:
It is your responsibility to be compliant with your physical therapy appointments and progress to meet your goals. If you are being seen for a workers compensation injury, we are required to communicate missed or cancelled appointments to your case manager and/or insurance company.

1. Understand that it is my responsibility to consult a physician before beginning any exercise program.
2. I am aware that there exists the possibility of certain conditions occurring during or following training and/or exercise. This include, but are not limited to: mild light headaches, fainting, abnormalities of blood pressure and/or heart rate, injuries to bones, joints and muscles, neck or spinal injuries, ineffective heart function, and in rare but serious instances, heart attach, stroke, or death.
3. I understand that I am voluntarily participating in these activities and understand that I may, at any time, choose not to participate in a particular activity.
4. I understand that I may not use any clinic equipment or participate in any clinic activity outside the course of my physical or occupational therapy treatment without discussion with the physical or occupational therapist.
5. I agree and have been informed that exercise involves possible risks and all exercises are undertaken at my sole risk and that neither Centex Rehabilitation, nor its directors, employees or agents shall be liable to me or any other person, for any claims, demands, actions or causes of action for injuries or other damages, whatsoever, to my person or property arising out of or connected with my use of clinical activities, classes or programs. I do hereby release and discharge Centex Rehabilitation thereof from all such claims, demands, actions or causes of action for such injuries or damages sustained by me.

I have carefully read and agree to all of the above policies of Centex Rehabilitation. In the event such policies are broken, I agree to the consequences set forth.

Patient Signature Date