Confidential Medical History **Arlington Physical Therapy**

Name: _____ Date of Birth: _____ Social Security # _____
Address: _____City: _____ State: _____ Zip: _____
Primary Phone: _____ Can you receive texts at this number? Yes No
Alternate Phone: _____ Email: _____
How would you like to receive appointment reminders? ___Text ___Call ___Email
Height: _____ Weight: _____ Sex: Male Female
What caused your current problem? _____
Chief Complaint: _____ Date of Injury:_____
Current Symptoms: Pain Numbness Stiffness Other:_____
Pain Level(0 = no pain, 10 =worst pain): _____ Condition: New Chronic
Have you had any of the following for this injury? None MRI X-Ray Other:_____

Do you or have you ever had any of the following?

Asthma, Bronchitis, Emphysema:	Yes	No	Arthritis/Swollen joints:	Yes	No
Shortness of Breath/Chest Pain:	Yes	No	Osteoporosis:	Yes	No
Coronary Heart Disease:	Yes	No	Varicose Veins:	Yes	No
Do you have a Pacemaker?	Yes	No	Gout:	Yes	No
Emotional/Psychological Problems:	Yes	No	Sleeping Difficulties:	Yes	No
Heart attack:	Yes	No	High blood pressure:	Yes	No
Stroke/TIA:	Yes	No	Dizziness or Faintness:	Yes	No
Blood Clot/Emboli:	Yes	No	Are you pregnant?	Yes	No
Epilepsy/Seizures:	Yes	No	Anemia:	Yes	No
Thyroid trouble/Goiter:	Yes	No	Type 1 Diabetes:	Yes	No
Infectious Disease:	Yes	No	Type 2 Diabetes:	Yes	No
Cancer or Chemo/Radiation:	Yes	No	Bowel/Bladder Problems:	Yes	No
Severe/Frequent Headaches	Yes	No	Vision/Hearing Difficulties:	Yes	No

Smoking: None Daily Weekly Alcohol Consumption: None Daily Weekly

Please list any allergies:_____
Please list all medications you are currently taking:_____
_____
_____
Please list any previous surgeries with the date:_____
_____
_____

How did you hear about us? Friend Family Website Doctor Other

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand I am responsible for any charges not covered by my insurance carrier. Furthermore, I understand I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Arlington Physical Therapy regardless of participation in or out of network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

SIGN AND DATE

Diagnostic Testing Screening Tool

Patient Name: _____ Date:_____

Dear Patient: _____

If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Therapist determine what diagnostic tests* might be appropriate for you.

Please check all that apply:

	Low Back and Radiating Pain		Neck Pain and Radiating Pain
	Numbness, Tingling or Burning Sensation in the Legs or Feet		Numbness, Tingling or Burning Sensation in the Arms or Hands
	Weakness in the Legs or Arms		Loss of sensation in Hands / Feet
	You have Diabetes or Neuropathy		Daily alcohol 3 glasses or more
	Thyroid Dysfunction		Muscle Disease / Muscle Cramping
	Tendinitis / Bursitis / Arthritis		Shoulder Pain or Instability
	Elbow Pain or Instability		Wrist-Hand Pain or Instability
	Hip or Knee Pain or Instability		Ankle – Foot Pain or Instability
	Blurred Vision		Hearing Problems
	Dizziness or Vertigo		Headaches
	Unsteady gait		History of falls due to dizziness
	Hypertension		Hypotension
	Anything else you consider important:		

Patient Signature: _____

For Office Use Only	This patient would benefit from this test	This patient would not benefit right now but may in the future	This test is not helpful and would not be considered for this patient
MSK Ultrasound			
EMG/NCS			

Referring Provider: __

Letter of Consent **Arlington Physical Therapy**

I hereby authorize Arlington Physical Therapy, P.C. to release any medical information necessary to process the claims and furnish information to insurance carrier(s) concerning my treatment and hereby assign to the therapist(s) all payments for services rendered.

I understand I am responsible for all allowable charges my insurance company does not pay.

I understand by signing I am giving my permission for treatment.

I authorize Arlington Physical Therapy, P.C. to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

I authorize the staff of this facility to say I am present or not present at this facility and provide information about my general condition to those persons listed below who are personally interested in my whereabouts and progress. I agree to have my next of kin as listed below notified in case of injury, illness, or emergency.

Name of Next of Kin		Telephone
Address		
City	State	Zip Code

Name(s) of Interested Persons	Relationship

I permit a copy of this authorization to be used in place of the original.

I understand this consent may be withdrawn by me, in writing, except to the extent authorized information has been disclosed in reliance upon it. In any event, this consent shall expire one (1) month after my discharge from this facility. I also understand any disclosure made on my behalf by this facility is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature Printed Name Date

Financial Policy **Arlington Physical Therapy**

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Copayments, coinsurances, and deductible allowable, if any, are due on each visit for charges incurred during your visit. We accept cash, checks, MasterCard, Visa, AMEX, and Discover. We bill electronically to expedite payment of claims whenever possible.

Please read carefully:

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard, and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.
4. **Medicare patients are responsible for their deductible and 20% of service charges (Medicare Fee Schedule Pricing for Tarrant County). Medicare recipients please sign below.**

_____

Signature SIGN AND DATE Printed Name Date

5. For liability or where another party is responsible and worker's compensation cases, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection must be received from your attorney before your treatment. For worker's compensation, the name of the adjuster, telephone number, and claim number is needed before your treatment. Without this information, you become responsible for the account in full.
6. Please understand attendance is vital to achieving your wellness goals. Our office requires a 24-hour notice for cancellation of appointments. You can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to reschedule. However, there will be a $50.00 fee for a missed appointment without proper notification to the office.
7. There will be a $25.00 fee for medical records less than 50 pages. For any medical records more than 50 pages, there will be a $50.00 fee.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility for the date the services are rendered. We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I have read the above policies and agree.

_____

Signature SIGN AND DATE Printed Name Date

Health Information Privacy Notice — Arlington Physical Therapy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. About Protected Health Information "PHI"

In this notice, "We", "Our", or "Us" means Arlington Physical Therapy, P.C. and our workforce of employees and volunteers. "You" and "You're" refer to each of our patients who are entitled to a copy of this notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulation requires us to protect health information about you in the manner we describe here. Certain types of health information may specifically identify you. Because we must protect this health information, we call this Protected Health Information or "PHI". In this notice we will tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or with a complaint

2. Some of the Ways We Use or Disclose Your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care. We are allowed to use or disclose your PHI for certain activities we call "health care operations". Health care operations involve many administration, education, and quality of assurance activities in our facility. We will give you examples of each of these to help explain them, but space does not permit a complete list of all uses or disclosures. For this reason, you may ask us questions.

Treatment

We use and disclose your PHI during your treatment. For example, you are evaluated by a physical therapist. The information is then shared in a report with your doctor. We may also use or disclose your PHI for many other types of treatment activities.

Payment

After we treat you, we will ask your insurer to pay us. We may type some of your HI into our computers and send a claim to your insurer. Here, we use your PHI to tell your insurer what type of health problem you had and what we did to treat you. Your insurer may ask us to give them your membership number in your employer's health plan or your insurer may want to review your medical records to be sure your care was necessary. When we use and disclose your PHI in this way, it helps us get paid for your care and treatment.

Health Care Operations

We also use and disclose your PHI in our health care operations. For example, our therapists meet periodically to study medical records to monitor the quality or care in our facility. Your medical records and PHI could be used in these quality assessments. Sometimes, we train physical therapists in our facility and use the PHI of real patients to test them or their skills. Other operational use or disclosures may involve business planning of our facility or resolution of a complaint.

Social Uses

We also use or disclose your PHI for purposes involving your relationship to us as a patient. We may use or disclose your PHI to:

- Remind you of your appointment with us for treatment
- Tell you about treatment alternatives and options
- Tell you about our health benefits and services

Your Authorization May Be Required

In many cases summarized here, we may use or disclose your PHI either with your consent or as required or permitted by law. In all other cases, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you later change your mind, you may revoke your authorization.

3. Certain Uses and Disclosure of your PHI Required or Permitted by Law

Many laws and requirements apply to us that affect your PHI. These laws and regulations may either require us or permit us to use or disclose your PHI. From the federal health information privacy regulations, here is a list describing required or permitted uses and disclosures.

- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself
- If we receive certain assurances that protect your privacy, we may use or disclose your PHI for research

We may also use or disclose your PHI:

- When required by law. For example, when ordered by a Court to turn over certain types of your PHI, we must do so.
- For public health activities such as reporting an adverse drug reaction to the Food and Drug Administration
- To report neglect, abuse, or domestic violence
- To the government proceeding such as in a response to a valid subpoena
- In judicial or administrative proceedings such as in response to a valid subpoena
- When properly requested by law enforcement officials
- If we reasonably believe to do so will avert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
- In connection with certain types of organ donor programs

4. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized here.

You're Right to Request Limited Use or Disclosure

You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request, we must abide by that agreement.

You're Right to Confidential Communication

You have the right to receive confidential communications from us at a location you provide. We require that you make your request in writing, provide us with the address, and explain to us if the request will interfere with your method of payment for your care.

You're Right to Revoke Your Consent or Authorization

If you have granted us your consent or authorization to use or disclose your PHI, you may revoke consent or authorization in writing. However, if we have relied on your consent or authorization, we may use or disclose your PHI to that extent.

You're Right to Inspect and Copy

You have the right to inspect and copy your PHI. We may refuse to give you access to your PHI if we think it may cause harm, but we have to explain why and give you someone to contact about our decision who will know how and when to get a review of our refusal.

You're Right to Amend Your PHI

If you disagree with what your PHI in our records says about you, you have the right to request in writing that we amend your PHI when it is in the record we create or have maintained for us. We are not required to respond to your request if the records you are asking about are not our records. We may refuse to make your requested amendment. Then, you will have the right to submit a written statement about why you disagree. If we still disagree, we may prepare a counter statement. Your statement and our counter statement must be made part of our record about you.

You're Right to Know Who Else Sees Your PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years. You cannot ask for disclosures before August 10, 2010. We do not have to account for all disclosures, including those involving treatment payment and health care operations as described above. There is no change for an annual accounting but there may be for additional accountings. We will tell you if there is a charge for your accounting and you will have the right to withdraw your request, or pay to proceed.

Your Rights to Complain

If you believe your privacy rights have been violated, you have the right to make a complaint to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint, you should submit it in writing to the contact person identified in this notice (below 6). Your complaint should provide a reasonable amount of specific detail to enable us to investigate a potential problem.

5. Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you notice of our privacy practices. This document is our notice. If you did not get a paper copy of this notice, you may have one. We will abide by the privacy practices set forth in this notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us.

6. Contact Information

If you have any questions about this notice, or if you have a complaint, please contact:
Name: Ana Maria Madrid, PT Title: Privacy Officer 2310 W I-20 Suite 204 (817) 466-7276

_____

Signature *SIGN AND DATE* Printed Name Date

NOTICE

Federal Law protects the confidentiality of the patients of this facility. It is unlawful to disclose any information about a patient, even their name to anyone. By signing into the facility you agree to abide by these Federal Laws and not disclose any information or the identity of anyone here.

_____

Signature Printed Name Date

Patient's Rights and Responsibilities **Arlington Physical Therapy**

Rights

1. You have the right to dignified and respectful care.
2. You have the right to know about and understand your physical condition.
3. You have the right to obtain any information requested by you to give informed consent before any treatment and /or procedure.
4. You have the right, at your own expense, to consult with another physician or specialist.
5. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal.
6. You have the right to be treated in a safe environment free of physical and psychological threats.
7. You have the right to privacy regarding visitors, mail, and/or telephone conversations.
8. You have the right to expect that all communications and records regarding your care will be held confidential.
9. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice.
10. You have the right to communicate verbally or in writing with anyone outside the practice and to expect that an interpreter will be provided if language is a barrier.
11. You have the right to know the identity, professional status, and institutional affiliation of anyone treating you.
12. You have the right to request an itemized statement of all services provided to you through this practice.
13. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.
14. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

Responsibilities

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.
2. You are responsible for participating in the development of your plan of care.
3. You are responsible for attending scheduled therapy and participating in activities prescribed by your treatment plan.
4. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice. You are responsible for following practice rule and regulations.

Concern/Complaint Procedure

We want to hear from you if you have any concerns, complaints, or compliments regarding your stay treatment and care in our practice. Please inform any staff member. Response to a concern/complaint will take place within 24 hours. Concerns/complaints will be monitored and the information utilized to improve our program.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.

_____

Signature Printed Name Date

Attention All Patients

You must reschedule or cancel your appointments by 2:00 PM the day before to avoid a $50 fee. Additionally, no-shows will also result in a $50 charge.

Thank you for your understanding,
Arlington Physical Therapy

Cancellation Policy

Dear Valued Patient,

At APT our mission is for you to get back to living your life pain-free. We want you to have the power to thrive mentally, spiritually, and physically. At APT we hold our employees to a high standard. We will respect you and your time by giving you our full attention throughout each visit and give you the best possible treatment we can provide. We ask that you show us the same courtesy by keeping your appointments or canceling them with appropriate notice.

A last-minute cancellation or no-show affects three people:

1. Yourself – by not showing up to your appointment you are preventing yourself from fully experiencing the healing process.

2. Others – we have an extensive wait-list. Appointments you cancel at the last minute could have been given to another patient who is trying to meet their own goals.

3. Our therapists and staff – we work hard to make sure you have the best opportunity to succeed; we want you to respect our time and effort.

Because we believe consistency and respect are critical to both your success and ours, all cancelations must be made by 2 p.m. on the day before your appointment. Failure to comply will result in a $50 charge and a hold placed on your account until the fee is paid.

We understand life gets in the way and unforeseen circumstances do arise. Nonetheless, it is still your responsibility to communicate with our staff in a timely manner so that all issues may be resolved in a way that respects the individuals mentioned above.

Canceling or rescheduling appointments is simple: call our front office at **(817) 466 7276, ext. 1** and speak with one of our staff OR leave a voicemail with your name, appointment time, and cancellation/ rescheduling instructions.

We appreciate your compliance and for allowing us to serve you.

Please sign below in acknowledgment of this Cancellation/No-Show policy:

Signature Print Name Date