Patient Contact Information

Patient Name_____ Today's Date_____

Address_____ City_____ State____ Zip _____

DOB_____ Age _____ Gender_____ Marital Status_____

Cell Phone _____ Home Phone _____

Email_____

Employer_____ Occupation_____

Parent/Guardian/Spouse

Name_____

Address_____City_____State_____

Cell Phone _____ Occupation_____

Emergency Information/ Nearest Relative

Name_____ Relationship_____

Address_____ City_____ State___ Zip _____

Cell Phone_____ Home Phone_____ Work Phone_____

PATIENT QUESTIONNAIRE

Physician_____

Date of injury or onset of symptoms _____ Date of surgery _____

Briefly describe your symptoms (how did it start / what caused it; nature of pain; areas affected)

_____

_____

_____

_____

What is this condition most limiting you from doing that you need, want, or love to do?

_____

Have you ever been treated for this or something similar?

_____

List any tests that have been performed and the results (ex X-ray, MRI, CT Scan)

_____

_____

Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture)

_____

_____

Please list all previous injuries, accidents, surgeries (include year) and any other pertinent medical information

_____

_____

_____

Please list *all* medical conditions and/or health concerns

_____

_____

_____

Please list *all* current medications:

_____

_____

_____

Please list all allergies:

_____

Do you now have or have you had any of these symptoms in the past year? (check all that apply)

___ Change in bowel movements
___ Persistent joint pain
___ Unexplained Weight Loss
___ Irritable bowel
___ Vertigo or dizziness
___ Persistent nose bleeds
___ Learning disabilities
___ Tiredness/fatigue
___ Difficulty Sleeping
___ Fainting spells
___ Shortness of breath
___ Recurring Headaches

Other_____

_____

_____

OFFICE POLICIES & PROCEDURES

Welcome and thank you for choosing Therapist On The Go for your Physical Therapy needs.

Texas Law and the State of Texas Physical Therapy Board requires patients to have a written Referral from a licensed medical person (MD, DO, DC, DDS, DPM, ANP, PA). It is your responsibility to obtain and maintain a current referral prior to evaluation and during your treatments.

CANCELLATION POLICY

As a courtesy to others and our Therapists and to other patients trying to get scheduled, we require a 24-hour (or greater) notice for cancellations. This allows others on waiting lists to be seen.

CONSENT TO TREATMENT

Therapist On The Go is a hands-on Physical Therapy clinic. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of deep tissue massage, therapeutic exercise programs, gait training, neuromuscular re-education, myofascial release, bone and soft tissue manipulation, trigger point dry needling, as well as other treatment modalities may be used.

The number of treatments needed and recovery time can vary widely due to the age of injury, number of times injured, age of patient and many other contributing factors.
I have read and fully understand the above statements. I understand the nature of the treatments at Therapist On The Go and I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

PAYMENT AGREEMENT

Thank you for choosing Therapist On The Go as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

- Out-of-Network Policy. Therapist On The Go is a fee-for-service clinic. This means that Therapist On The Go is not “in-network” with any private health plans. Payment is due at the time of service and we will not bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may submit to your private insurance company. Such receipts cannot be made available if you are a Medicare beneficiary.

- We accept cash, personal checks, and credit cards.

- Privacy Rights. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy and we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Disclosure to Release Protected Health Information form before we will disclose your health information.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE WRITTEN STATEMENTS AND PAYMENT TERMS.

X _____ Date: _____
Signature of patient/legal guardian

Therapist On The Go

Photograph, Video, and Testimonial Release Form

Video recordings of our treatments as well as written/video testimonials from our patients help us get the word out about what we do and how we can help others. They also help us to teach others how to replicate our methods and better help their patients. With that said, please read below and let us know if you'd be okay with us recording and using any part of your treatment sessions and/or possibly writing/recording a testimonial for our clinic.

…

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- marketing videos
- On line educational courses
- educational videos
- for-profit endeavors

By signing this release I understand this permission signifies that photographic or video recordings of me, and my written text, may be electronically displayed via the Internet or in the public educational setting. I understand that I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. I have been informed that I can revoke this consent at any time and Therapist On The Go will discontinue further use or disclosure at that time.
I realize that if any information has been posted on the internet, Therapist On The Go cannot control how my photographs, videos or testimonials are used by others.

I realize that the above items cannot be restricted from use/disclosure for treatment, payment or operations.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational or marketing purposes.

Full Name_____

Signature_____ Date_____

If this release is obtained from a client under the age of 18, then the signature of that client's parent or legal guardian is also required.

Parent's Signature_____ Date_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information
Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

HIPAA 143a-Authorization for Release of PHI 10-28-08

1. Patient's Printed Name:

_____
Last First Initial or Other

2. Therapist On The Go will only disclose the protected health information you want disclosed. Check only one box to tell Therapist On The Go the specific information you want disclosed/released:

- ☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)
- ☐ Limited information (complete ALL Sections)
- ☐ ALL records regarding my care at Therapist On The Go to any requesting party (skip 3 and 4)

3. Complete only if you selected "limited information". Please initial all that apply:

___ Evaluation/Examination ___ Attendance ___ Correspondence re: your Physical Therapy Services
___Past Medical History ___ Treatments ___ Other _____

4. Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ Other: _____

5. Check only one box indicating how long Therapist On The Go can use this authorization:

- ☐ Disclose my information indefinitely (as long as Therapist On The Go has custody of my files)
- ☐ Disclose my PHI for the following period beginning ___/___/_____ and ending ___/___/_____

6. Please initial all items below indicating that you have read and understand the rights or information below:

___I understand that this authorization does not expire unless I have indicated an expiration date above
___I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
___I understand that if I give authorization I may revoke it at any time by notifying Therapist On The Go in writing
___I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
___I understand that if Therapist On The Go requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
___I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
___Therapist On The Go will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

_____ or _____

Signature of Patient Date Signature of Parent or Authorized Representative Date (Indicate the Relationship)

You May Refuse to Sign this Authorization