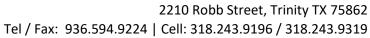






# PATIENT INTAKE QUESTIONNAIRE FOR REHABILITATION CLINIC

Name:	
(First)	(Last)
Email:	Phone Number:
Address:	<del></del>
Why are you seeking therapy?	
Describe your injury. How and When it started	J?
Are you currently working?	□ No
Employment:	me 🗆 Student 🗆 Retire 🗖 Disabled 🗖 Other
Occupation:	Employer: Length of Employment:
	· · · <u></u>
HOME STATUS / FUNCTIONAL LEVEL:	
Live with ☐ Alone ☐ Spouse / Part	ner 🗆 Family 🗖 Friends 🗖 Other
Home	nent
☐ Apartment with/without el	evator
Maximum number of stairs to walk at any on	ne time in home Are there any handrails?
HEALTH HISTORY	
Currently receiving any Home Health or Hosp	pice services:
Previous therapy for this injury or ailment:	☐ Yes ☐ No If yes, how many visits? When?
Number of falls in the last month:	In the last year?
Do you? Smoke ☐ Yes	□ No if yes, how much
Drink Alcohol	□ No if yes, how much
Check each condi Caffeine	☐ No if yes, how much





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☐ Pacemaker/Defibrillator		Heart Disease/Attac	ck 🛭 Skir	n Disease		Circulation Problems
☐ Osteoporosis/Osteopenia		Stomach Disorders	□ ні∨	/ (+)		Blood Clots
☐ Arthritis (OA, RA)		Liver Disorder	☐ Mei	ntal Health Iss	ues $\square$	Metal Implants
☐ Bleeding tendencies		Kidney Disease	☐ Lur	ng Disease/Ast	hma 🗖	Stroke
□ Cancer ()	□ во	wel/Bladder Issue	☐ Seizure Dis	sorder	☐ Preg	nant (#of Mos)
☐ High Blood Pressure	☐ Thy	roid Disease	☐ Unexplain	ed weight	☐ Neu	rological Disorder
☐ Diabetes (Type	_)	☐ Allergies			Unexpect	ted weight gain/loss
☐ Frequent Nausea / Vomiti	ng	☐ Tape / Latex	Allergy		Other:	
ADAPTIVE / ASSISTIVE EQUIPM	ENT OWN	ED				
None Crutches W	heeled wal	ker Transfer tub	bench	Bedside Co	ommode	Hospital Bed
Cane Walker W	/heelchair	Grab bars		Lift Chair		Other
			<i>.</i>			
List any surgeries that may be	associated	with your condition	(include date):			
List all current medications inc	cluding ove	r the counter types (I	f you have a list	t, we will phot	ocopy it)	
How frequently are you using	pain medio	cations for this condit	ion?			
Every 3-4hours	Daily	Weekly	Intermitte	ently / As need	ded	Do Not Use
What are you using for pain?						
		Rate your	pain on a scale	of 0-10 (0-N	o Dain 1	N-Worst Pain
Area/s of Pain		Current	At E	-		: Worst
	_					
	_	your symptoms getti	· ·		☐ Wor	se
	_ Are	your symptoms gene	_			
	_	Better / Worse in th	ie morning [	☐ Better / W	orse in th	e afternoon
		Better/Worse While	Sleeping [	□ Better the	n worsens	s as the day goes on



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Area/s of Numbness/	Tingling	Pain Behavior:		Constant Burning Aching Radiating		Intermitten Stabbing Sharp		□ Dull □ Throbbing
Have you had any of	the following	g for this condition? If	yes, s	state result	S			
None		CT scan				EMG _		
X-ray		Bone scan				Diagnostic	c / Ar	throscopy
MRI		Arthrogram_				Doppler/Ult	raso	und
<ul><li>□ None</li><li>□ Medication:</li><li>□ PT/OT</li></ul>	☐ Massa☐ Exerci☐ Inject	ions	apply	☐ TENS☐ Tract☐ Surge	Unit ion ery			Bracing Pain Clinic Othe <u>r</u>
☐ Chiropractic ☐ Acupuncture ☐ Splinting / Taping  Functional Limitations: Place a check to each activity that causes you pain or difficulty.								
☐ Sitting	☐ Laying	g on back / side / ston	nach	☐ Putti	ng on sc	cks / shoes		Reaching to floor
☐ Standing	☐ Bathir	ng Tasks		☐ Goin	g Up / D	own stairs	□ ı	ifting to waist level
☐ Walking	☐ Groom	ning Tasks		☐ Oper	n / Close	Doors		Reaching Overhead
☐ Sleeping	☐ Dressi	ng Tasks		☐ Carry	ing iten	ns while walki	ing _	
What are your goals	for therapy?							

PLEASE RETURN TO THE FRONT DESK WHEN COMPLETED. THANK YOU





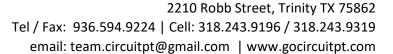
## CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist and treatment by a licensed physical therapist assistant by or under contract with Circuit Physical Therapy.

The physical therapist has fully explained to me the nature and purpose of the procedures, evaluation, and course of treatment, and has witnessed my signature of this consent in his/her presence. The physical therapist has informed me of the expected benefits and possible complications and discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

The physical therapist has explained that in some cases, physical therapy treatment may not improve my condition and although unlikely, it can cause additional pain or aggravation of my condition, intervention, prognosis, expectations, and plan of care was able to answer my questions to my satisfaction.

I attest that I have fully read and ur	nderstood the consent	form.	
Patient / Guardian Signature	Signature	/ Print Name	
 Date	Relation	ship, if signed by person other th	 at client





## **PATIENT EMERGENCY CONTACT SHEET**

Name:			
-	First		Last
Relationship:			
Address:			
	Apt /Street		
-	City	State	Zip code
Cell Phone:			
Name:			
-	First		Last
Relationship:			
Address:			
	Apt / Street		
-	City	State	Zip code
Cell Phone:			



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## PATIENT RESPONSIBILITY FORM

#### 1. INDIVIDUAL FINANCIAL RESPONSIBILIT

- I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the cost of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

#### 2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to CIRCUIT PHYSICAL THERAPY on my behalf for any services furnished to me by the providers.

## 3. AUTHORIZATION TO RELEASE REORDS

I hereby authorize CIRCUIT PHYSICAL THERAPY to release my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services, as well as information required for precertification, authorization, or referral to other medical provider.

#### 4. INSURANCE REQUEST FOR PAYMENT

I request payment of authorized insurance benefits to me or on my behalf for any services furnished to me by CIRCUIT PHYSICAL THERAPY. I authorized any holder of medical or other information about me to release to insurance and its agents any information needed to determine these benefits or benefits for related services.

	_
Signature of Patient, Authorized Representative or Responsible Party	Date
Print Name of Patient, Authorized Representative or Responsible Party	 Date



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## NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DICLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FORM CAREFULLY.

#### **OUR LEGAL DUTY**

CIRCUIT PHYSICAL THERPAY (CPT), is required by law to protect the privacy of your personal health and information, provide notice about our information management practices, and follow the information protocols described below.

#### **USES AND DISCLOSURES OF HEALTH INFORMATION**

CIRCUIT PHYSICAL THERPAY, uses your personal and health information for treatment obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing tracking, and research studies. In any other situation, CPT will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosure at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. Our HIPAA Compliance Officer is Catherine Mallari. She can be reached at the office by calling 936-594-9224.

#### PATIENT INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency.

CPT will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

#### **CONCERNS AND COMPLAINTS**

If you are concerned that CPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Catherine Mallari, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Circuit Physical Therapy	
HIPAA Compliance Officer	Initials
Attention: Catherine Mallari	
22210 S. Robb St, Trinity TX 75862	
Tel / Fax: 936 594 9224   Cell: 318 243 9196	Date



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## **CANCELLATION FEE**

Circuit Physical Therapy is committed to providing you with the highest quality of care and in order to maintain that level of excellence we ask that you provide at least 24-hour notice of a cancellation.

We do realize that things come up like illness, transportation issues, hazardous driving conditions, or family emergencies that make it impossible to keep your scheduled appointment.

Cancellations without 24-hour notice will be accepted in these circumstances on a one-time basis only. Any additional instances will be subject to a \$20.00 charge and must be paid at your next scheduled visit. Not showing for your appointment (no show) is unacceptable and a fee of \$20.00 will be charged in every instance.

This fee will be expected to be paid at your next scheduled visit. This fee is not covered by your insurance and it will be your responsibility to pay no matter what type of coverage you have. If the fee is not paid, you will be billed and this balance is subject to collections. Please be considerate of other patients and our staff and call as soon as possible if you are unable to attend your scheduled physical therapy visit.

Date