ON CALL
PHYSICAL THERAPY
And Wellness

Patient Name: _____ Gender: _____

Date of Birth: _____ Age:_____ Social Security#:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Can we send text messages and/or leave voice messages to the listed phone number(s) about appointment reminders?

( ) Yes / ( ) No Data and messaging rates may apply.

What e-mail address can we use to send updates about our clinic? _____

Employment (If Applicable):

Place of employment: _____ Job Title: _____

Primary Insurance:

Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____

Secondary Insurance (if applicable):

Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____

Guarantor's Name (if patient is a minor): _____ Date of Birth: _____

Address: _____ Phone:_____

Worker's Compensation / Auto Injury Patients (If applicable):

Carrier Name: _____

Case Manager/Adjuster Name: _____

Case Manager/Adjuster's Phone Number: _____

Attorney Name: _____ Phone Number: _____

Referring Physician: _____

Primary Care Physician: _____

I understand that On Call Physical Therapy and Wellness, LLC (d.b.a. "On Call Therapy Services") will file my claims for services rendered to my insurance company. I agree to pay all fees such as and not limited to copays, co-insurance and deductibles not covered by the insurance company and will assume full financial liability if my insurance coverage does not cover On Call Physical Therapy and Wellness, LLC services. I also authorize On Call Physical Therapy and Wellness, LLC to release portions of my medical records to the insurance carrier and/or payor of our services in order to secure payment.

Assignment of Benefits: I also authorize On Call Physical Therapy and Wellness, LLC to receive payment directly from my insurance carrier.

Signature: _____ Date: _____

Printed Name: _____

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MEDICAL HISTORY

Current Condition:

Where is your pain? _____

When did it begin? _____

What caused your condition? _____

Is it work related? _____

Is it related to an auto accident? _____

Please list previous treatments and/or medications you are taking for your condition: _____

_____

Have you had physical therapy in the past for this condition? ( ) Yes or ( ) No

If yes, please provide details (such as when you had physical therapy, what they treated you with and if physical therapy was successful): _____

_____

Have you EVER or currently have one of the following conditions?

(Please check conditions that apply to you)

( ) Rheumatoid Arthritis
( ) Cancer
( ) Osteoporosis
( ) Osteopenia
( ) Diabetes
( ) Stroke
( ) Heart Attack
( ) Congestive Heart Failure
( ) Acid Reflux
( ) Infectious disease (such as HIV/AIDS, Hepatitis, COVID-19, TB)
( ) Fibromyalgia
( ) Osteoarthritis
( ) Seizures
( ) Lung disease
( ) Hypoglycemia/Low blood sugar
( ) Other (please specify): _____

Do you have a pacemaker/cardiac defibrillator? ( ) Yes or ( ) No

Are you currently pregnant? ( ) Yes or ( ) No If so, how many weeks? _____

Are you allergic to latex? ( ) Yes or ( ) No

Do you have any known allergies to anything (including medications)? _____

Have you ever had surgery? ( ) Yes or ( ) No

If so, please list the surgeries you have had along with the approximate dates of your surgeries?

_____

_____

Please list current medications you are taking: _____

_____

The above information is true and accurate to the best of my knowledge. Should my health condition change, I will notify On Call Therapy Services immediately.

Signature: _____ Date: _____

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Consent to treatment:

The patient or legally authorized representative authorizes the Physical, Occupational, and/or Speech Therapist staff to examine and treat the condition as he/she deems appropriate through the use of physical/occupational, and/or speech therapy measures, and the patient or legally authorized representative gives authorization for these procedures to be performed. The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Physical, Occupational, and/or Speech Therapist. The patient will not hold the Physical, Occupational, and/or Speech Therapist responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis.

The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

I have read (or have had read to me) the above information and understand the content.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name

NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Abi Balogun, On Call Therapy Services, 214.230.2040, 2109 W. Parker Road Ste 208, Plano, TX 75023

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Signature of Patient or Legal Representative	Witness
Date	Date

ON CALL PHYSICAL THERAPY and Wellness

HOW DID YOU HEAR ABOUT US?

Please tell us how you heard about our office:

_ I was referred to you by the physician ordering physical therapy.

_ I was referred to you by a physician other than the ordering physician.
Please list physician here: _____

_ Your office was recommended to me by a friend/relative.
Please list this person's name: _____

_ My insurance company gave me your information.

_ I found you in the phone book.
Which phonebook? _____

_ I found you on a search engine.
Which one (circle)? Google Yahoo Other: _____

_ I found you on social media.
Which one? Please list: _____

_ I found you on your website.

_ I am a former patient of yours.

_ Other: _____

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Home Health/Outpatient Questionnaire

1. Are you or have you recently received home health services?

   Yes No

2. If you answered yes to the above question, please write the name and phone number of the home health agency:

   _____

   _____

3. How long did you receive home health services for?

4. What date were you discharged from home health?

5. Have you had OUTPATIENT physical therapy during the current calendar year?

   Yes No

6. If you answered yes to question #5 please tell us when you had outpatient physical therapy, how many sessions did you attend and for what condition were you treated for:

   _____

   _____

   _____

   _____

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Cancellation/No-Show Policy

We value you as a patient and want you to receive the maximum benefit from our therapy program. We schedule patients and give specific appointment times so that you can conveniently and efficiently make use of your time. We ask that you do the same for us by keeping your appointment schedule.

If you need to cancel one of your appointments at our office, we require at least 24-hour notice. Failure to do so may result in a $25.00 fee that you will be responsible for (insurance companies do NOT pay for missed appointments). If you no-show or cancel (without 24 hours' notice) for 3 appointments at our office, you will be discharged from our practice. Also, frequent cancellations (with 24+ hours of notice), may lead to you being discharged from our practice. If you cancel frequently, we will only be able to schedule 1 future appointment at a time.

Please note that our office informs the referring physician, payer sources such as insurance companies and/or worker's compensation case managers of any of our patient missed appointments at our office. This can affect your continuation of physical therapy services and in some cases your ENTIRE worker's compensation, insurance or injury claim can be denied. Please make sure you attend ALL of your scheduled physical therapy appointments. If you miss an appointment, make sure to reschedule that appointment in the same week.

I have read and understand the above policy.

_____ _____

Signature of Patient or Legal Representative Date

_____

Patient or Legal representative Name

**Please note: This policy applies to all patients, even if you refuse to sign this form.

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Authorization to Share Protected Health Information (PHI)

I authorize On Call Physical Therapy Services to discuss my Protected Health and/or Billing information with my spouse, family member(s) or friend(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize On Call Therapy Services to discuss or release billing information only to my Attorney(s) listed below:

Attorney Name: _____

Address: _____

Law Firm: _____

Phone: _____ Fax; _____

Type of Case: □ Workman's Compensation □ Auto Accident □ Personal Injury

Date of Injury or Accident: _____

This authorization shall expire no later than three (3) years from date of signature. I understand that after my health information is disclosed, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law; however, refusal to sign would affect On Call Therapy Services ability to communicate with your attorney and/or the listed persons above. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to on Call Therapy Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name: