TRUE CARE PHYSICAL THERAPY

Name: ____ D.O.B: _____________

Address: ____

City: _____________________ State: _____________ Zip: ________ Ht: ____ Wt:____

Home Phone # _____________________________ Cell Phone # ___________________

Employer ___________________________________ Work Phone # ________________

Position: _______________________ SS#: _________________ Marital Status: _______

Employers Address: ___________________ City: ______________ St. ___ Zip: _______

Email address: ____

Can we contact you by email: ____ Yes ____ No

Emergency contact:
Relation: ___________________________ Phone: _______________ Cell: ___________

Have you had MRI or X-rays done for this injury: ______

If so, where: ____

On a scale from 1 – 10, describe your pain level at this time: _____ (0 indicates no pain, 10 is the worst pain)

Briefly describe your symptoms/pain: ____

____

Brief medication description of hospitalizations, treatments, pertaining to this visit: _____

____

____

Other medical conditions not listed above: _____________________________________

____

____

Women only – are you pregnant? ____ Yes ____ No

Have you received any Home Health Services in the past 3 months? ____ Yes ___ No
If you answered yes, please list the name of H.H. agency and Phone #:

____

Patient Signature: _______________________________________ Date: _____________

How did you hear about us? ____

TRUE CARE PHYSICAL THERAPY

2222 Airline Rd., Ste A9

Corpus Christi TX, 78414

Medical Release Authorization

Patient Name: ____

D.O.B. __________________________________ SS# ______________________________

I authorize **TRUE CARE, P.T.** to communicate with outside physicians, companies, and any other health professionals, concerning my medical health and billing records held by: **TRUE CARE, P.T. (SAME ADDRESS)**. PHONE: (361) 853-6500 FAX: (361) 853-6501.

I further authorize the electronic, digital, or verbal communications of records or information between **TRUE CARE, P.T.** and any insurance company, physician office, or any other healthcare agency associated with the medical treatment. All treatments, accidents, and illnesses are covered by this release. I further agree to hold harmless **TRUE CARE, P.T. AND STAFF** concerning the release of any medical records.

Patient signature: ___________________________________ Date: _________________

Witness: ____ Date: _________________

I DO/DO NOT (Circle one) agree to authorize the release/discussion of sensitive medical records or those records whose disclosure is protected by law. These include records concerning communicable diseases, and mental health records concerning chemical dependency. I understand that the refusal to release this information may affect the standard of care available to the patient as the staff would be limited in disclosure of my complete medical condition.

I do not agree (sign here): ______________________________ Date: ________________

TRUE CARE, P.T.
2222 Airline Rd, Ste A9
Corpus Christi TX, 78414

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protect health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protect health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).

Obtaining payment from third party payers (e.g., my insurance company).

I have also been informed of and given the right to review and secure a copy of your **Notice of privacy practices,** which contains a more complete description of the uses and disclosures of my protected health information, and my rights under **HIPPA**. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used the disclosed to carry out treatment, payment, and health care operations, but then you are not required to agree to these requited restrictions. However, if you do not agree, you are then bond to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signed this ______________________________ day of ___________________________ 20_____

Print Patient Name ____

Relationship to patient ____

Signature ____

Patient Refusal to Sign: ____

TRUE CARE PHYSICAL THERAPY
<u>Financial Policy, Insurance Authorization, and Release of Information</u>

The following is a statement of our financial policy, which we require you to read and sign prior to receiving any treatment.

Regarding Insurance: As a courtesy to you, we will bill you insurance company (primary and secondary). We will complete the necessary forms to help expedite insurance carrier payments. However, the Patient is **responsible** for all fees not covered by your insurance plan. Any dispute about your coverage needs to be settled between you and your insurance company.

Outstanding Balances: After the insurance has paid, you will be responsible for any balance that your insurance applies to your responsibility, unless you have made payment arrangements with the **Office Manager.**

Medicare does not pay for maintenance therapy once a patient has stopped progression. If he/she wishes to continue treatment then he/she will be required to sign Medicare Form (CMS-R-131-G, ABN) **ADVANCE BENEFICIARY NOTICE.** At that time the patient will be responsible for the remaining treatments. Please read form carefully before signing.

I hereby voluntarily consent **TRUE CARE P.T.** to release any/all information to my referring physician and any required information to my insurance companies to file for medical services. I also authorize payment of all benefits be made payable to **TRUE CARE P.T.** My signature below also acknowledges that I have read and understood **FINANCIAL POLICY OF TRUE CARE, P.T.**

Cancellation of Appointments: I will notify THE OFFICE 24 hours prior to my appointment if I need to reschedule or cancel my appointment. I UNDERSTAND THERE MAY BE A CHARGE IF I FAIL TO COMPLY WITH APPOINTMENT SCHEDULE.

Patient signature: ____ Date: _____________

MEDICATION LIST

Patient Name: ____

MEDICATION	DOSAGE	FREQUENCY	PT Initials and Date	PT Initials and Date

TRUE CARE PHYSICAL THERAPY
NOTICE OF PATIENT INFORMATION PRACTICES

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

TRUE CARE P.T.'S LEGAL DUTY

True Care P.T. uses your personal health information primarily for treatment; obtaining payment for treatment; conduction internal administrative activities and evaluating the quality of care we provide. For example, True Care P.T. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

True Care P.T. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, True Care policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason you may later revoke that authorization to stop future disclosures of any time.

True Care P.T. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You gave the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than a treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. True Care P.T. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that True Care P.T. may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complain to the US Department of Health and Human Services. For further information on True Care P.T. health information practices, or if you have a complaint, please contact the following person.

ANGIE DIAZ, OFFICE MANAGER
TRUE CARE PHYSICAL THERAPY
2222 AIRLINE RD, STE A 9
CORPUS CHRISTI, TX 78414
(361) 853-6500 FAX (361) 853-6501

Signature: ____ Date: __________________