Castroville Physical Therapy
& Sports Medicine Rehabilitation

Before Your Visit

Initial Evaluation

- Arrive 5-10 minutes prior to your scheduled appointment to complete paperwork.
    - If you are late for your appointment, it may be rescheduled depending on our Physical Therapist's schedule
- Ensure that you have your insurance card and driver's license/state ID as we will make copies of it for our records.
- Be prepared to make a payment towards your co-pay, deductible or co-insurance.
- Wear comfortable clothing that will allow you to exercise without restriction (i.e. shorts for hip or knee treatments, tank tops for shoulder treatments).
- Allow 90 minutes for your first appointment.
- Based on your diagnosis and referral, one of our physical therapists will examine your level of function, strength, and range of motion.
- You and your therapist will create a plan of care to accomplish your goals while at therapy.
- You will receive a home exercise program to begin immediately. Completing this routinely will be key to functional improvement.

Make sure you are discharge from All Home health

Treatment Sessions

- Please be changed and ready for therapy at your scheduled time.
- Allow 90-120 minutes for subsequent therapy appointments.
- Wear comfortable clothing that will allow you to exercise without restriction.
- Keep in mind how you are doing between appointments and provide feedback to the staff about your functional progress. Communication with your Physical Therapist is the key to success.
- Remember, participation in the home exercise program prescribed at the initial evaluation is essential to recovery!

2309 HWY 90 W • Castroville, TX 78009
(830) 538-3344 • Fax (830) 538-3346

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Consent to Treatment

I voluntarily consent for Castroville Physical Therapy & Sports Medicine Rehabilitation to perform rehabilitative treatment and care as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I authorize the physical therapist to perform any additional or different treatment, which is deemed necessary should, during treatment, a condition be discovered which was not known previously.

I consent and authorize Castroville Physical Therapy & Sports Medicine Rehabilitation to administer treatment under the direction and supervision of the physical therapist.

I understand that this consent to treatment will be valid and remain in effect as long as I attend treatment at Castroville Physical Therapy & Sports Medicine Rehabilitation unless revoked by me in a written notice provided to the clinic. I certify that I have read this form or had it read to me and that I understand the contents.

_____

Patient/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Leave messages to confirm or verify appointment information.
- Conduct normal healthcare operations such as quality assessments and physical therapist certifications.

I have been offered the opportunity to fully read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address shown to obtain a current copy of the NOTICE OF PRIVATE PRACTICES. We want to assure you that your medical/protected health information is secure with us. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

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Cancellation & No-Show Policy

Effective December 1, 2014, Castroville Physical Therapy is implementing the following policies:

CANCELLATION POLICY: Patients will be charged a $25.00 fee if the office is not notified 24 hours prior to their scheduled appointment time.

NO-SHOW POLICY: Patients will be charged a $40.00 fee for missed appointments.

*In emergency cases, there are exceptions. However, we encourage you to schedule appointments that you will be able to make. With a limited amount of appointment slots, cancellations and no-shows greatly affect our business and take away time for fellow patients to be seen.

If you have any questions, feel free to contact our Office Manager. Thank you for your understanding and cooperation with these policies.

I have read and/or had the above policy explained to me. I understand and will abide by the policy above.

_____

Patient/Guardian Signature Date

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits; to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to Castroville Physical Therapy & Sports Medicine Rehabilitation and/or its affiliates for services rendered. I understand that I am financially responsible for charges whether paid by my insurance company. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further authorize that my signature on this form constitutes an assignment of benefits to this healthcare provider.

I consent to have Castroville Physical Therapy & Sports Medicine Rehabilitation and/or its affiliates to provide the treatment and care prescribed by my physician(s). I understand that this consent may be revoked by me at any time.

_____

Patient/Guardian Signature Date

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Registration Information

Last Name:	First Name:	M.I:	Date of Birth:
MAILING Address:	City:	State:	Zip Code:
Cell Phone #:	Other Preferred #:	SSN #:	
Email Address:			
Emergency Contact Name:	Contact #:	Relationship:	

Employer Name:	Occupation:
Work #:	

Referring Physician

Physician First Name:	Last Name:	Phone:
Address:	City:	State/Zip Code:
Diagnosis:		

Primary Insurance

Insurance Name:	ID #:	Group #:	Phone #:
Policy Holder Name:	Relationship:	SSN #:	DOB:

Secondary Insurance

Insurance Name:	ID #:	Group #:	Phone #:
Policy Holder Name:	Relationship:	SSN #:	DOB:

Castroville Physical Therapy
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Patient Medical History

Name: **DOB:** **Date of Injury:**

Please <u>circle</u> any condition for which you have received treatment

High Blood Pressure	Asthma	Recent Weight Loss/Gain
Heart Problems	Emphysema	Thyroid Problem (Hyper or Hypo)
Abnormal Heart Rate	Chronic lung Problem	Diabetes (Medical Dependent? _____)
Pacemaker	Chronic Heartburn	Cancer (Where? _____)
Heart Palpitations	History of Ulcers	Epilepsy/Seizures
Angina (chest pain)	High Cholesterol	AIDS/HIV Positive
Heart Murmur	Bowel or Bladder Problems	Other: _____
Abnormal Bleeding		

Do you have history of fractures?	Yes	No	Where? _____
Do you have history of back/neck pain?	Yes	No	When? _____
Do you have metal implants?	Yes	No	Where? _____
Do you smoke?	Yes	No	How much per day? _____
Do you exercise regularly?	Yes	No	How often? _____
Do you have known drug allergies?	Yes	No	Please list: _____

Current Condition

Rate your level of pain: **No Pain [0-1-2-3-4-5-6-7-8-9-10] Severe Pain**	
Do you have any "pins and needles" or numbness in your extremities?	YES NO
Do you have any weakness in your arms or legs?	YES NO
Do you have any coordination or balance problems?	YES NO
Do you have difficulty walking?	YES NO
Do you experience dizziness of vertigo with a change in position?	YES NO
Have you experienced headaches as a result of your condition?	YES NO
Were you injured in a work-related accident?	YES NO
Please list all current medication:	
Please list all surgeries and dates:	
Please check diagnostic tests performed: [] X-ray [] MRI [] CT Scan [] Bone Scan [] Bone Density [] EMG [] U/S	
Please describe your chief complaint and current condition:	

I certify this information to be true and accurate.

_____

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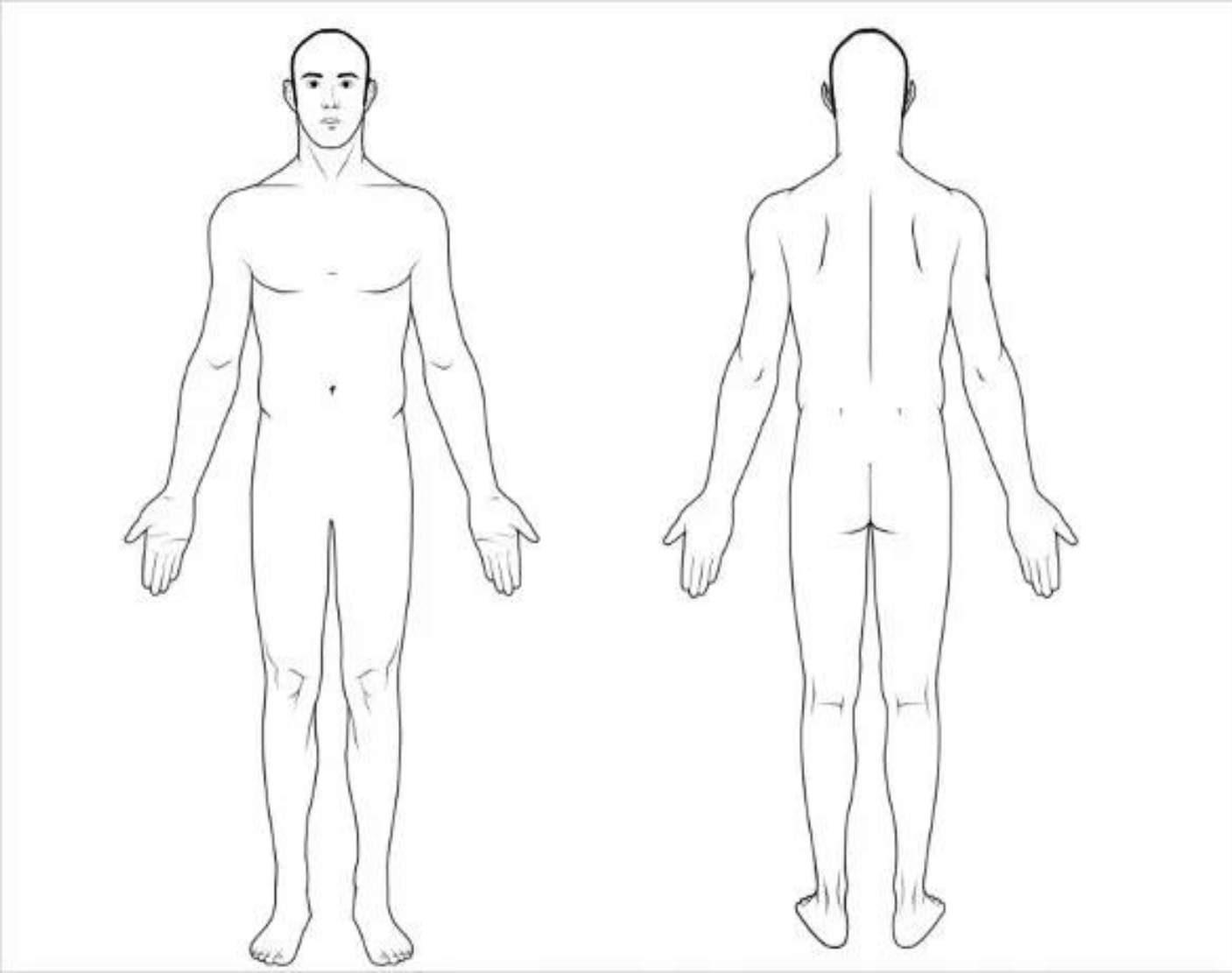
Please Circle the area(s) where you have pain on the Diagram:



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