PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

_____

_____

_____

_____

Mailing Address:

_____

_____

_____

Phone Numbers: **OK To Call** **Best Time To Call**

Home: _____ ☐ _____

Work: _____ ☐ _____

Cell: _____ ☐ _____

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: _____

Preferred language: _____ **Interpreter required?** ☐ Yes

Date of Injury: _____ **Referring Physician:** _____

Injury Area: _____ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured: _____

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other _____

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Patient **Date**

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:** _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:** _____

LIABILITY

I know and agree that:
is not responsible for loss or damage to personal valuables. **Initials:** _____

WAIVER AND RELEASE

I hereby release, discharge and acquit:
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:** _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to:
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:** _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials: _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** _____
I acknowledge receipt of the Statement of Patient Rights. **Initials:** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

WEST WOODLANDS PHYSICAL THERAPY

WEST WOODLANDS PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAYS DATE: _____
REFERRING PHYSICIAN: _____ DATE OF INJURY/ONSET: _____
PRIMARY CARE PHYSICIAN: _____ ARE YOU PRESENTLY WORKING ☐ YES ☐ NO
CAUSE OF INJURY/ ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY FEVER, COUGH, CHILLS, OR OTHER FLU LIKE SYMPTOMS ☐ YES ☐ NO IF YES, EXPLAIN:
_____

HAVE YOU FALLEN IN THE PAST YEAR? ☐ YES ☐ NO IF YES, HOW MANY TIMES : _____
IF YES, DID YOU SUSTAIN ANY INJURIES FROM THE FALL? ☐ YES ☐ NO
IF YES, EXPLAIN: _____

HAVE YOU HAD ANY PRIOR PHYSICAL OR OCCUPATIONAL THERAPY THIS YEAR? ☐ YES ☐ NO
IF YES, EXPLAIN: _____
WHAT IS YOUR REASON FOR ATTENDING PHYSICAL THERAPY? _____
BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
   _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES THAT YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
DO YOU USE TOBACCO? ☐ YES ☐ NO IF YES, HOW MUCH? _____
DO YOU WEAR GLASSES OR CONTACTS? ☐ YES ☐ NO IF YES, WHICH _____
HAVE YOU RECENTLY BEEN HOSPITALIZED? ☐ YES ☐ NO
IF YES, WHEN: _____
MEDICATION ALLERGIES: ☐ YES ☐ NO IF YES, EXPLAIN: _____
ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO IF YES, EXPLAIN: _____
ARE YOU ALLERGIC TO DEXAMETHASONE? ☐ YES ☐ NO IF YES, EXPLAIN: _____
FEMALE PATIENTS: ARE YOU CURRENTLY PREGNANT OR NURSING? ☐ YES ☐ NO
PREVIOUS SURGERIES:
_____
_____
CURRENT MEDICATIONS:
_____
_____

DO YOUR CURRENTLY HAVE OR HAVE A HISTORY OF THE FOLLOWING HEALTH CONDITIONS? (CHECK ALL THAT APPLY)

☐ ANEMIA	☐ DIABETES	☐ RESPIRATORY PROBLEMS
☐ ARTHRITIS	☐ DEPRESSION	☐ ASTHMA
☐ CANCER	☐ DIZINESS/ FAINTING	☐ COPD
☐ CARDIOVASCULAR	☐ FRACTURES	☐ SEIZURES
☐ HOLTER MONITOR	☐ HEADACHES	☐ THYROID PROBLEMS
☐ HIGH BLOOD PRESSURE	☐ HEPATITIS / HIV	☐ BLOOD THINNERS
☐ LOW BLOOD PRESSURE	☐ MRSA	☐ OSTEOPEROSIS

ANY OTHER MEDICAL CONDITIONS:
_____
_____

SIGNATURE OF PATIENT: _____ DATE: _____
REVIEWED BY THERAPIST: _____ DATE: _____

WEST WOODLANDS
PHYSICAL THERAPY

CONSENT TO USE ARTIFICAL INTELLIGENCE SCRIBE TECHNOLOGY

Patient Name: _____ Date of Birth: _____

I acknowledge that __West Woodlands Physical Therapy __, ("Provider") will be using an artificial intelligence (AI) scribe software service ("Software") during my physical therapy visits. This Software will create notes in real-time, allowing my Provider to focus on me and less time on documenting our therapy encounter.

By initialing and signing this Consent to Use Artificial Intelligence (AI) Scribe Technology Form, I expressly certify that I understand:

_____ 1. Provider will be using the Software service to capture conversations between Provider and myself to auto-generate Provider's documentation and administrative work.

_____ 2. The Software will process an audio recording of the conversation between Provider and me and will record my protected health information to auto-generate Provider's draft note.

_____ 3. The provider will use the draft note to document and sign the final note that becomes part of my electronic medical record.

_____ 4. The audio recording will be stored securely after Provider has finalized and signed the note and transferred it to my electronic medical record. The audio recording will be stored in accordance with the security regulations of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

_____ 5. The audio recording of my protected health information will be used for clinical purposes, only, which includes treatment, payment, or health care operations in accordance with HIPAA. It will not be used for any other purposes.

_____ 6. I may revoke this Consent at any time by giving written notice to Provider, except to the extent that Provider and its agents, employees, and representatives may have taken prior action in reliance on this Consent. I have read all the information above, or it has been read to me. I have had the opportunity to ask questions about the Software, and any questions I have asked have been answered to my satisfaction. By initialing the above statements and signing below, I expressly consent to use the Software and to have my visits recorded to support my Provider's clinical work.

_____ _____

Patient/Responsible Party Date

_____

Parent/Legal Guardian (If Patient is a Minor)

WEST WOODLANDS
PHYSICAL THERAPY

OFFICE CANCELLATION/NO-SHOW POLICY

Thank you for choosing West Woodlands Physical Therapy for your rehabilitation needs. Our policy is to be as understanding as possible when scheduling your physical therapy visits.

If you are unable to make your scheduled appointment, **please call 24 hours in advance.** We will reschedule your appointment for the first available time.

Please note that **any appointment that is not canceled 24 hours before the scheduled time** and is not rescheduled within the same business week **will have an automatic charge** of **$45.00** added to your account. This amount should correspond at the time of your next visit.

If you don't keep your appointment and haven't called, we'll follow up with a call to schedule the appointment. Three no-shows or cancellations will result in a drop from care at the clinic until your doctor receives a new physical therapy order.
If you are a workers' compensation patient, your adjuster will be notified immediately.
By signing below, you acknowledge that you have read and understood the above policy.

_____ _____

Patient/Responsible Party Date

_____ _____

Clinic Staff Date