EXOS®

PHYSICAL THERAPY

**Patient Information Sheet**

Patient _____ Physician _____

**Personal Information**

Birthdate _____ Age _____ Social Security # _____

Home Address _____

Street/City/State/Zip _____

Home Phone _____ Cell Phone _____ Sex _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed Spouse's Name _____

Emergency Contact _____ Relation _____ Phone _____

**Employment Information**

Student: Full-time _____ Part-time _____ If so, where _____

Employed: Full-time _____ Part-time _____

Employer _____ Occupation _____

Address _____ Work Phone _____

**Spouse's Employment Information**

**(Only if policy holder is spouse)**

Spouse's Employer _____ Occupation _____

Address _____ Work Phone _____

**Primary Insurance Coverage**

Insurance Company _____ Group # _____

Policy Holder _____ Birthdate _____ Policy or ID# _____

Effective Date _____ Relationship of Patient to Policy Holder _____

Policy Holder Social Security Number _____

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# Patient Medical History Form

Name: _____ DOB: _____

To help us better evaluate your condition please complete this form to the best of you knowledge. Thank you.

**MEDICAL HISTORY: (Please check any condition you have a history of. Items not checked are understood to be negative.)**

___High Blood Pressure
___Heart Problems
___Abnormal Heart Rate
___Pacemaker
___Angina (chest pain)
___Shortness of Breath
___Osteoporosis
___Arthritis
___Abnormal Bleeding
___Asthma
___Emphysema
___Chronic Heartburn
___History of Ulcers
___High Cholesterol
___Night Sweats
___Dizziness
___Bowel or Bladder Problems
___Autoimmune disorder
___Recent Weight Loss/Gain
___Diabetes
___Cancer/tumor (location_____)
___Seizures/Epilepsy
___Chronic Heartburn
___Hearing Problems

Other: _____

| | | | |
|---|---|---|---|
| Do you have a history of fractures? | YES | NO | Where? _____ |
| Do you have a history of back/neck pain? | YES | NO | When? _____ |
| Do you have any 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 any known allergies (latex)? | YES | NO | Please List? _____ |
| Are you pregnant or suspect pregnancy? | YES | NO | |
| Do you work outside of the home? | YES | NO | If yes, what do you do? _____ |

**Current Medications:** _____
_____
_____

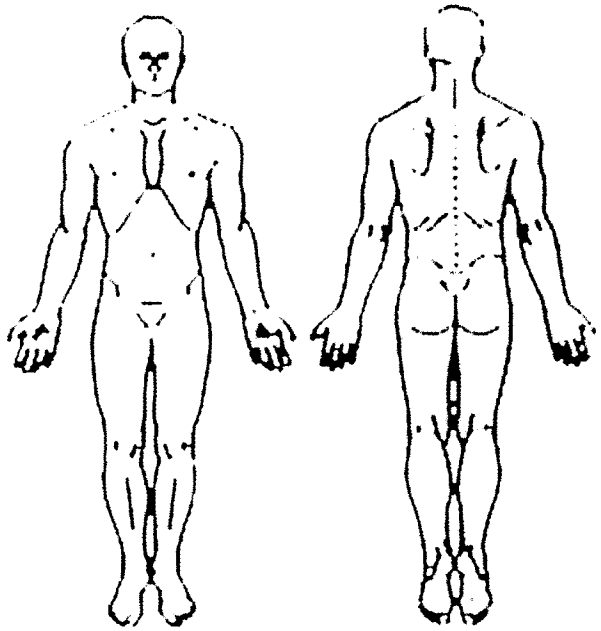
**Past Surgeries:** _____
_____
_____

**Diagnostic Tests:** Please check test(s) for current problem only

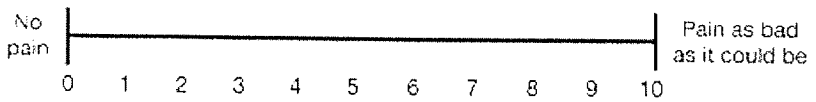
( )X-Rays ( )CT Scan ( )MRI ( )Bone Scan ( )EMG
( )Bone Density ( )Blood Chemistry ( )Ultrasound
( )Other (please specify)_____

What makes your pain better? _____
_____
What makes your pain worse? _____
_____

What type of pain do you have? (Circle all that apply)
*Aching Numbness Pins and Needles Burning*
*Sharp/Stabbing Throbbing Other*



Please indicate on the picture where you feel your pain and place an **X** on the scale below for your **current level of pain.**




By signing below, I attest that I have personally reviewed the information on this sheet

Signature_____ Date_____

**Texas Sport and Spine/EXOS Physical Therapy**

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

**Uses and Disclosures**

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For instance, results of laboratory tests and procedures kept in your medical record will be available to all health professionals who may provide treatment to you or who may be consulted by staff members relating to your care.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information regarding dates of service, the services provided, and the medical conditions being treated.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Texas Sport and Spine/EXOS Physical Therapy. Budgeting and financial reporting are examples of such usage.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For instance, we are required to report certain communicable diseases to the state's public health department.

**Research.** We may access your health information for research purposes; this may include Institutional Review, Board-approved and regulated clinical studies as well as retrospective reviews of patient outcomes.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you wish to change a previous authorization, you may to do so by submitting to our office a written revocation of that previous authorization. Please be aware that your decision to revoke the previous authorization will not affect or undo any prior use or disclosure of information associated with the initial authorization.

**Additional uses of information.** Appointment reminders. Our staff will use your health information to remind you of pending appointments.

**Information about treatments.** Your health information may be used to send you information on the treatment and management of your medical condition or on other health-related goods and services that you find to be of interest.

**Acknowledgement of Receipt of Notice of Privacy Practices**
**Texas Sport and Spine/EXOS Physical Therapy**

I have received a copy of the above described Notice of Privacy Practice form, and I understand the rights of privacy as afforded me therein. Furthermore, I understand that reserves the right to modify the privacy practices outlined in the notice.

_____

**Name of Patient (Print or Type)** **Signature of Patient** **Date**

_____ _____

**Signature of Patient Representative** **Relationship to Patient**

(Required if the patient is a minor or an adult who is unable to sign this form.)

## Release of Protected Health Information

My protected health information may be released to the following person(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

***If pt is a student athlete, can private health care information be discussed with the school's certified athletic trainer? Please sign below to give consent.**

_____ _____

Signature of Patient or Parent/legal guardian if less than 18 yrs old Date

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# Physical Therapy

## Cancellation/No Show Policy

Due to the limited time slots available for therapy appointments, it is important that all patients attend their as-scheduled appointments. If you are unable to attend, it is expected that you call and inform us at **(325) 698-4545 (ext. 251)** at least **24 hours** prior to your scheduled appointment. If you arrive 10 minutes after your scheduled appointment time, your treatment time may be decreased due to time constraints. **As a policy, if you have 2 or more no-shows, we reserve the right to discontinue services.**

I have read and understand this policy.

Signature:_____ Date:_____

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Texas sport & spine

EXOS Physical Therapy Welcome Letter

**Welcome**

Welcome to EXOS Physical Therapy. It is our ultimate goal to provide you with the finest and most professional level of care and patient services. Working in conjunction with your physician, we are uniquely equipped and prepared to make your therapy experience the most effective and efficient possible. We are here to serve you and assist you in your recovery, recuperation, and rehabilitation. So, please, share with us any questions, concerns, and/or comments. We look forward to working with you to achieve your therapy goals.

**Patient Responsibilities**

As a valued patient of EXOS Physical Therapy, you are responsible for the following:

1) Keeping your therapy appointment and arriving on time
2) You are responsible for any required deductibles or co-pays
3) Wearing comfortable and loose fitting clothing
4) Turning off any cell phones during your visit, or please keep cell phone on silent

**Scheduling**

Your therapy appointments are critical to your progress and recovery, and it is important that you make every effort to attend ALL your therapy sessions. If, for some reason, you cannot make your appointment, we require that you call at least 24 hours in advance to reschedule.

**Failing to report to your therapy for three consecutive appointments will result in our discharging you from therapy.** Additionally, if you have not been seen in the last 30 days you must first revisit your referring physician before therapy can resume. Subsequent visits will require a new order from your physician.

We respect your time and schedule; consequently we always strive to see you at your scheduled time. Occasionally, the patient appointment preceding yours may run longer than its allotted time. If you are required to wait longer than 10 minutes beyond your appointment time, please discuss this matter with your therapist.

If you have any questions at all, please feel free to call us at 325-665-5090.