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: _____
_____
_____

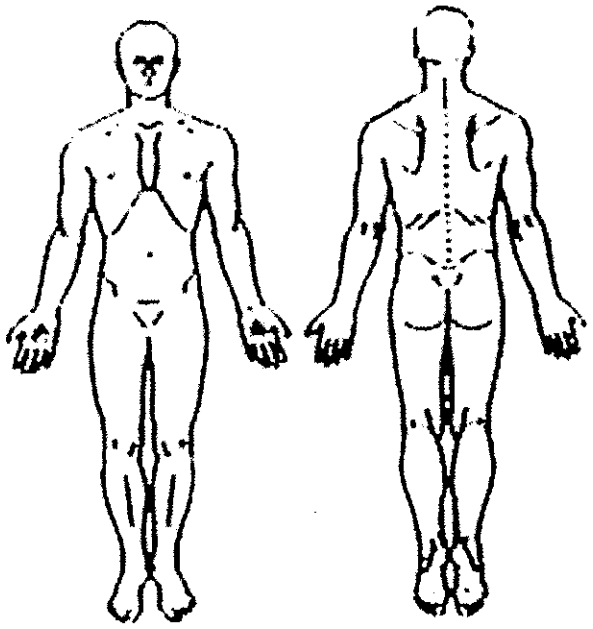
Past Surgeries: _____
_____
_____

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.**

No pain — Pain as bad as it could be

0 1 2 3 4 5 6 7 8 9 10

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

Signature_____ Date_____

Consent For Care Form

Date:_____ Patient Name:_____

Insured's Name:_____ Insurance Company:_____

Insurance Type: ☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ WC Ref/Cert required: Yes No

Ref/Cert #/details:_____

IN-NETWORK	Amount/Met
Deductible:	_____
Out-of-pocket:	_____
Co-pay per visit:	$_____
Coinsurance	
Insurance %	_____
Patient %	_____

OUT-OF-NETWORK	Amount/Met
Deductible:	_____
Out-of-pocket:	_____
Co-pay per visit:	$_____
Coinsurance	
Insurance %	_____
Patient %	_____

Number Of Visits Authorized Per Year:_____ # Of Visits Remaining:_____

Maximum Therapy Limit ($):_____ **Per Visit Self-Pay Agreement:** $_____

Verified By (PT Employee):_____ Spoke With (Ins Employee):_____

Please read and sign the disclaimer below:

The information above has been recorded based on the benefits and eligibility supplied to us by your insurance carrier and is not a guarantee of payment or benefits. Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangement for payment of your estimated share be made today. If payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Texas Sports and Spine/EXOS Physical Therapy. The above does not apply for those patients considered Worker's Compensation; however, as a Compensation patient you may be held responsible for your charges in the event your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Texas Sports and Spine/EXOS Physical Therapy, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If further therapy is required beyond the above authorization period, I will follow-up to make sure that any additional authorization has been obtained from the insurance carrier prior to any additional treatment, if this is required by my insurance company. If I incur rehabilitation without appropriate authorization from my carrier, I will be responsible for the charges in full as well as any non-covered services. I will also be liable for all treatment that exceeds what is allowed by my insurance plan. It is my responsibility to ensure this information remains valid throughout my treatment.

_____ Signature of Patient or Responsible Party Date: _____

Consent For Care And Treatment

I, the undersigned, do hereby agree and give consent to Texas Sports and Spine/EXOS Physical Therapy to furnish medical care and treatment to
_____ considered necessary and proper in diagnosing or treating their physical and mental condition.

_____ Patient/Guardian 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

EXOS®

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:_____