ELITE
THERAPY SOLUTIONS

New Patient Registration

Patient Information:

Name (Last, First):_____ Date: _____

Address: _____
Street City State Zip Code

Phone (Home):_____ (Work): _____ (Cell): _____

Social Security Number: _____-_____-_____ Birth Date: _____/_____/_____ Sex: (M / F)

Email: _____ Alternate Email: _____

Employer (of insured party): _____ Employer Phone: _____

Address: _____
Street City State Zip Code

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____-_____-_____

Patient Relationship to Policy Holder: _____

Physician Information:

Name of Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____

Name of Primary Care Physician: _____ Phone: _____
(If different than referring physician)

Address: _____City: _____ State: _____

Emergency Contact:

Name: _____

Phone (Home): _____ (Cell): _____

Relationship to Patient: _____

Medical History
Social Questionnaire

Patient Name: _____ DOB: _____

Do you now or have you ever had any of the following? (Check all that apply)

_____ Diabetes	_____ Arthritis	_____ High Blood Pressure
_____ Heart Attack	_____ Heart Disease	_____ Pacemaker/Surgical Implant
_____ Vascular Disease	_____Headaches	_____ Kidney Problems
_____Open Wounds	_____ Current Infections	_____ Allergies
_____ Hernia	_____ Seizures	_____ Metal in Body
_____ Cancer/Tumor	_____ Thyroid Problems	_____ CVA/Stroke
_____ Previous Fractures	_____ Osteoporosis	_____ Depression
_____ Anxiety	_____ Substance Abuse	_____ Previous Surgeries
_____ Asthma	_____ Presently Pregnant	_____ Hepatitis (A, B, C)
_____ Hypersensitivity to Heat/Cold		_____ Other _____

Approximate Date of Injury: _____ /_____ /_____

Explanation of Injury: _____

_____

_____

Are you presently taking medications? YES / NO

If yes, list medications & specify condition: _____

_____

Do you currently have transportation to and from physical therapy? YES / NO

Do you currently have financial difficulties that prohibit you from coming to physical therapy? YES / NO

Are you currently (Circle all that apply)

Employed Unemployed Retired – Date _____ Disabled – Date _____

Are you currently receiving, or in the last 30 days, have you received Home Health (HH) services from anyone for any type or procedure? YES / NO

****Please notify front desk if you have received or are receiving Home Health****

If yes, Please write agency name, phone number, and doctor's name who ordered Home Health.

Agency Name: _____ Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Ordering Physician: _____ Date HH Began: _____/_____/_____

_____ _____

Patient/Guardian Signature Date

Elite Therapy Solutions
2100 N. Greenville Ave. Suite 100
Richardson TX, 75080
Phone: (972) 644-0701
Fax: (972) 644-0003
At Jerome's Gym

Name: _____ Date: _____

Physician: _____ DOB: _____ Age: _____

What are we seeing you for today? _____

Specific date of injury/onset of symptoms: (mm/dd/yy) _____

How did it occur? _____

List any previous treatments for this episode: _____

Notes: _____

_____

Past medical history: (check all that apply):

High Blood Pressure	_____ Yes ____ No	Osteoporosis	_____ Yes ____ No
Heart Problems	_____ Yes ____ No	Blood Clots	_____ Yes ____ No
Neurologic Disorders	_____ Yes ____ No	Diabetes	_____ Yes ____ No
Pacemaker	_____ Yes ____ No	Cancer	_____ Yes ____ No
Osteoarthritis	_____ Yes ____ No	Seizures	_____ Yes ____ No
Pregnant	_____ Yes ____ No _____ Unsure		
Surgery (list type): _____		Other: _____	

Any recent health changes (i.e. significant weight gain/loss; bowel bladder problems; fever; dizziness, changes in vision and/or speech, ect.)? If so, please list: _____

_____

Are you taking any medications? (please list) _____

Allergies to medications? (please list) _____

Have you had any of the following tests for this specific incident? __CT Scan __ MRI __ X-Ray __EMG __Bone Scan

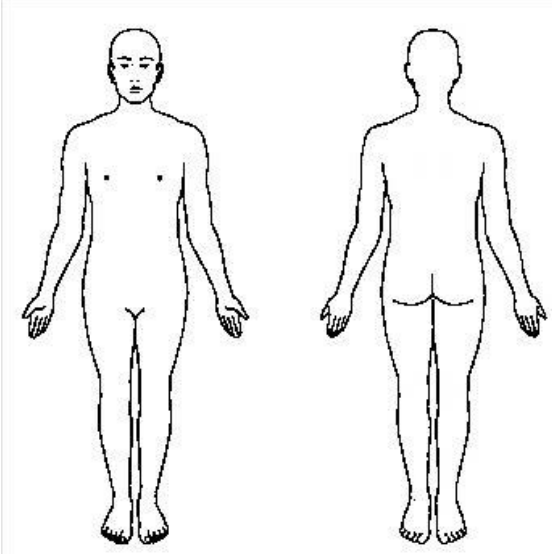
1. Do you have difficulty sleeping? ___Yes ___No Why? _____
   What position do you sleep? _____ How many pillows do you use? _____
2. Have you had physical therapy for this problem before? ___ Yes ___ No When? _____
3. Are you currently being treated by another healthcare provider? ___ Yes ___ No Who? _____
4. What was your level of activity prior to your injury? (circle one) High Moderate Low
5. Are you currently working? ___ full time ___ light duty ___off ___ homemaker___ N/A
6. What is your occupation? _____
7. What does your occupation require? ___ lifting ___push/pull ___writing ___sitting
   ___ walking ___ twisting ___ reaching ___computer/typing
   ___ standing ___ carry ___ climbing ___ kneeling/crouching
   ___ repetitive movements ___ other: _____
8. When is your next doctor's appointment? _____ With Whom? _____

9. Do you have difficulty with the following tasks?

	YES	NO		YES	NO
Getting in / out of bed	____	____	Driving	____	____
Dressing / Grooming	____	____	Recreational Activity or sport	____	____
Housework	____	____	Climbing stairs / curbs	____	____
Laundry	____	____	Grocery shopping / Errands	____	____
Bending / Stooping	____	____	Standing 30 minutes	____	____
Walking	____	____	Lifting / Carrying	____	____

10. Describe your pain:

Mark areas of PAIN with an "X" Mark areas of numbness/tingling with "O"



My pain is: ___ aching ___ burning ___ stabbing ___ pins and needles

___ dull ___ sharp ___ other: _____

Rank your pain on a scale of 0-10

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Intensely Severe Emergency Room

11. When time of day is your pain the worse? (circle one): Morning Afternoon Evening

12. Is your pain CONSTANT / COME AND GO ? (circle one)

13. What makes your pain worse? _____

14. what eases your pain? _____

_____ _____ _____ _____

Patient/Guardian Signature Date Reviewed by Therapist Date

Optimal Instrument
Difficulty Baseline

Patient Name: _____ Date: _____

INSTRUCTIONS: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling Over	1	2	3	4	5	9
3. Moving –lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/Stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking – short distance	1	2	3	4	5	9
11. Walking – long distance	1	2	3	4	5	9
12. Walking – outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

23. From the above list, choose the three activities you would most like to be able to do without any difficulty (for example: if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. *13* 2. *8* 3. *14*)

    1. _____ 2. _____ 3. _____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty you would choose: Primary goal: *13*)

    Primary goal: _____

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We would like to thank you for choosing Elite Therapy Solutions for your physical therapy needs and look forward to working with you to achieve your goals. We ask for your assistance in reviewing and understanding our payment policy. If you should have any questions, please do not hesitate to ask, we are more than happy to help you. After you have reviewed the policy *please complete and sign the registration on the other side.*

- Co-pays are due at the time of service
- We accept cash, personal checks, MasterCard, Visa and Discover
- We will be happy to help you process your insurance claim form for your reimbursement
- We do accept assignment
- We realize that temporary financial problems may arise affecting timely payment of your account. Please contact our office manager if problems arise, we will be delighted to work with you.

By signing, you agree to:

- Pay any and all charges that are not otherwise paid by your insurance carrier. These charges could include amounts applied to your annual deductible, co-payment amounts, and charges denied as not covered by your insurance program or deemed medically necessary.
- In the event your account should be referred to a collection agency or lawyer for collection, you agree to pay any and all collection fees and or court costs.

Your therapist will gladly discuss your proposed treatment with you, but all questions relating to your insurance company will be directed to the office manager.

Please realize that your insurance is a contract between you, your employer and the insurance company.

We are not a party to that contract.

Not all services are a covered benefit in all contracts.

ELITE
THERAPY SOLUTIONS
2100 N. GREENVILLE AVE SUITE 100
RICHARDSON TX, 75082
PHONE: (972) 664-0701 FAX: (972) 664-0003

Thank you for choosing **Elite Therapy Solutions** for your physical therapy treatment. We have contacted your insurance company for your treatment, according to the Benefits the representative will be covered as follows:

DEDUCTIBLE: _____ MET: _____ BALANCE: _____

CO-PAYS: _____ CO-INSURANCE: _____

INSURANE PAYS: _____ OF RESASONABLE AND NECESSARY

The patient portion of these charges will be payable at the time of service. (In some cases, special arrangements can be made to pay these charges weekly.)

Although **Elite Therapy Solutions** makes every effort to charge fees in the line with most insurance companies definition of REASONABLE AND NECESSARY; sometimes the entire fee is not payable by insurance. It is to be understood that any amount not paid by insurance handing will become the responsibility of the insured.

I have read and understand the above and agree to the terms set forth in this document. I understand that although **Elite Therapy Solutions** is filing insurance benefits for me, the responsibility of the payment of this account is mine.

*******IF YOU HAVE ALREADY PAID YOUR DEDUCTIBLE TO ANOTHER FACILITY OR DOCTOR, WE WILL HOLD YOUR CLAIMS FOR TWO WEEKS.**

AFTER THAT, IF YOUR INSURANE DOES NOT PAY YOUR CLAIMS DUE TO YOUR DEDUCTIBLE, YOU WILL BE RESPONSIBLE. *****

_____ _____
Signature of Insured Date

_____ _____
Witness Date

Statement of Financial Responsibility

Elite Therapy Solutions is concerned about your health. We look forward to assisting you with your health care issues. Please remember that your health insurance is your responsibility, but we can help. Regardless of what we might calculate as your healthcare benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. As a courtesy to you, we can accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. We allow 90 days for your insurance company to make a payment. After that time all inquiries or follow up in payments due become your responsibility.

_____ _____

Patient/ Guarantor Signature Date

IF YOU RECEIVE MEDICARE, PLEASE READ THE FOLLOWNG, SIGN, AND, DATE

PATIENTS MEDICARE AUTHORIZATION

Patient's Name: _____

Patient's Medicare Number: _____

I request that payment of authorized Medicare benefits be made either to me or on behalf to:

Elite Therapy Solutions

for any services furnished me by that physicians/supplier. I authorize any holder or holder of medical information about me, to release information to the Health Care Financing Administration and its agents, any information needed determine these benefits payable to relatable services. I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If (other than insurance) is indicated in item 9 of the HCFA -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient/Guardian Signature Date

Notice of Our Privacy Practices

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

Effective Date: 4/14/2003

Revised Date: 2/12/2015

UNDER FEDERAL LAW, HOW MIGHT YOUR PROTECTED HEALTH INFORMATION NEED TO BE USED OR DISCLOSED BY OUR OFFICE FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATION PURPOSES?

Generally, your protected information may be used or disclosed by our clinic for treatment, payment, or specific health care operations. These three words or phrases are defined by Federal Law, 45 CFR s 164.501 and other regulations as follows:

Treatment: *Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another*.

Payment: *the activities undertaken by us to obtain or provide reimbursement for the provision of health care.* Such activities include without limit determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing; and review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.

Other Health Care Operations: 45 CFR s 14.501 and .520(b)(1)(iii) outline several other purposes for which our practice may use or disclose protected information. For example, our practice may use or disclose protected information for the purposes of (1) conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, (2) providing appointment reminders to patients, (3) providing treatment alternatives or other health-related benefits and services that may be of interest to patients, and (4) contacting patients to raise funds.

Disclosures to the Patient by Fax and E-mail

Periodically, patients request that our clinic transmits protected information to them by means of fax, e-mail, or leaving a message on voicemail regarding such information. While we may request specific written authorization from your prior to disclosing protected information through such means, you hereby agree (1) that providing us with a fax number, e-mail address, or phone number which includes voicemail, you are hereby consenting to disclosures through such means, and (2) in the event that you receive protected information from us via such means AND you do not wish to receive any more communication in these or other fashions, you agree that you will immediately instruct us in writing not to continue disclosing your protected information through such means.

Under Federal Law, How Might Your Protected Health Information Need to be Used or Disclosed in Ways That Do Not Require Written Consent or Authorization?

Under certain circumstances, law may require or permit our practice to make us of or to disclose your personal information without your consent or authorization. Such circumstances include:

a) Uses and disclosures required by law

b) Uses and disclosures for public health services

c) Disclosures about victims of abuse, neglect, or domestic violence,

d) Uses and disclosures for health oversight activities

e) Disclosures for judicial and administrative proceedings

f) Disclosures for law enforcement purposes

g) Uses and disclosures about decedents

h) Uses and disclosures for cadaveric organ, eye or tissue donation purposes

i) Uses and disclosures for research purposes

j) Uses and disclosures to avert a serious threat to health or safety

k) Uses and disclosures for specialized government functions

l) Disclosures for workers' compensation

What Happens If Other Law is More Restrictive than Federal Law?

In the event other law becomes more restrictive than Federal Law with respect to uses and disclosures of your protected information, our practice will include descriptions of the more stringent requirements in this privacy notice.

All Other Uses or Disclosures Require Your Written Authorization

All other uses and disclosures besides those listed herein and those which require an opportunity to agree or object (see 45 CFR 165.512) will only be made with your written authorization. Once such authorization is granted, you may revoke it at any time as provided by and subject to 45 CFR 165.508 (b)(5).

Your Rights and How to Exercise Those Rights

Under Federal Law, you have the following rights. To exercise your rights, you will need to send a written request to the attention of the Privacy Officer in our clinic.

You have the right to request restrictions on certain uses and disclosures of protected health information as provided by s 164.522(a). Please note however that under Federal Law, our clinic is not required to agree to a requested restriction.

You have the right to receive confidential communications of protected health information as provided by and subject to 45 CFR s 164.522 (b).

You have the right to inspect and copy protected health information as provided by and subject to 45 CFR s 164.524.

You have the right to amend protected health information as provided by and subject to 45 CFR s 164.526.

You have the right to receive an accounting of disclosures of protected health information as provided by and subject to 45 CFR s 164.528.

You have the right to obtain a copy of this privacy notice.

If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer of our clinic and to the Secretary of Health and Human Services. To file a complaint with our clinic's Privacy Officer, simply request and complete a copy of our privacy complaint form and submit it to our Privacy Officer. No individual may be retaliated against for filing such a complaint.

Duties of Our Clinic

Our clinic is required by law to maintain the privacy of your protected information and to provide you with notice of our legal duties and privacy practices concerning your protected information. Our clinic is required to abide by the terms of this privacy notice and to make new notice provisions effective for all protected information that our clinic maintains. The revised notice will be made available at the front desk of our clinic for your inspection or copying.

Contact Information for Further Information

Donna Alford

Office Manager/Privacy Officer

Elite Therapy Solutions

2100 N. Greenville Ave Suite 100

Richardson TX, 75082

2100 N. Greenville Ave. Suite 100
Richardson TX, 75082

Notice of Privacy Practice Acknowledgement

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

- Conduct, plan and direct my treatment and follow-up among the multiple heath care providers whom may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health care information. I understand that this organization has the right to change its Notice of Practices from time to time and that I may contract this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment of heath care operation. I also understand you are not required to agree to my requested restrictions, but if you so agree then you are bound to abide by such restrictions.

Patient Name: _____

Parent or Guardian (if minor): _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____

Reasoning: _____