Case Physical Therapy, Inc.
5757 Woodway, Ste. 140
Houston, TX 77057
713-840-8100

Dear Patient:

On behalf of the staff here at Case Physical Therapy, we would like to welcome you to our clinic. Our professional staff is committed to working with you to achieve your goals and to help you return to a fully productive and independent lifestyle.

To obtain the maximum benefit from your program, it is imperative that you attend and fully participate in all sessions and activities scheduled. Your physician will be updated on your progress continuously.

***Have you had any physical therapy this year (starting Jan. 2018), either here or at another clinic?** _____

***Did you obtain this injury due to an automobile accident or work injury?** _____

Prescription/Referral

The prescription that the doctor gave you to attend therapy is valid for 30 days from the date written by the doctor. **We CANNOT treat you without it, please bring it with you to your first visit, or have your doctor fax it to us. (Fax: 713-840-8110)**

Cell Phone Policy

As a courtesy to our staff and other patients, please refrain from using your cell phone inside our clinic.

I have read and understood the above policies:

Patient Signature: _____ Date: _____

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Please circle any sport you play:

Golf Tennis Soccer Football Basketball Baseball Running Other:_____

How did you hear about our practice?

Physician Friend/Relative *Stand Tall, Don't Fall* Marketing Website/Internet
Other: _____

Patient Name: _____

Date of Birth: _____ SS#:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Spouse Name: _____ Address: _____

Spouse Employer: _____ Address: _____

Responsible Party: _____ Address: _____

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

As a courtesy, Case Physical Therapy Inc. will file your insurance. Benefits are **not** a guarantee of payment. In the event that your insurance carrier does not make prompt payment, you will be responsible for contacting your carrier, and you will be **legally** responsible for the total amount due. Should you have any financial questions, please do not hesitate to ask.

I authorize William S. Case, PT, SCS, and/or Isabel Young, PT, FMS, to supervise any and all treatments which are deemed medically necessary for my referred condition.

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Outpatient Medicare History/Subjective Information

Name: _____ Referring Physician: _____
Date of first doctor visit for this event: _____ Occupation: _____
Has this event caused you to stop working? Y/N If yes, what is the last date worked: _____
Have you had surgery for this condition? (circle one) YES NO
Number of surgeries: 1 2 3 4 _____ Type of surgery: _____
Took place in (circle one): Hospital Surgery Center Height: _____ Weight: _____
Are you currently taking any prescription or Non-prescription medications? (circle one) YES NO
Anti-inflammatories: _____ Muscle relaxers: _____
List Medications (or attach sheet): _____

Medical History (Please check all that apply)

o Heart Disease o Cancer o Hearing/Visual Impaired o Osteoporosis	o Diabetes o Epilepsy o Stroke o Hepatitis	o High Blood Pressure o HIV/AIDS o Asthma o Kidney/Bladder Control	o Pacemaker o Arthritis o Latex Allergy o Dizziness

Current Issue History

How and when did the injury or pain occur? _____
_____
_____

Have you had any prior/previous treatment for this injury or pain? (Please circle all that apply):
XRAY MRI CAT SCAN Physical Therapy Injections
Chiropractic Services Massage Therapy Acupuncture
Other: _____

Pain Level

Is your pain: Constant Intermittent (please circle one)
Please rate your pain using a 0-10 scale: (please circle the number that applies to you)
0 = no pain at all, 5 = pain interferes with daily tasks, 10 = worst pain you can imagine, need to go to the hospital
Today's Pain? *0 1 2 3 4 5 6 7 8 9 10*
Worst pain since onset? *0 1 2 3 4 5 6 7 8 9 10*
Least pain since onset? *0 1 2 3 4 5 6 7 8 9 10*
What makes your pain/problem feel better? _____
What makes your pain/problem feel worse? _____

Physical Therapy Goals and Expectations

What problems are you experiencing because of your diagnosis or injury? _____
_____
What are your goals for physical therapy? _____
_____

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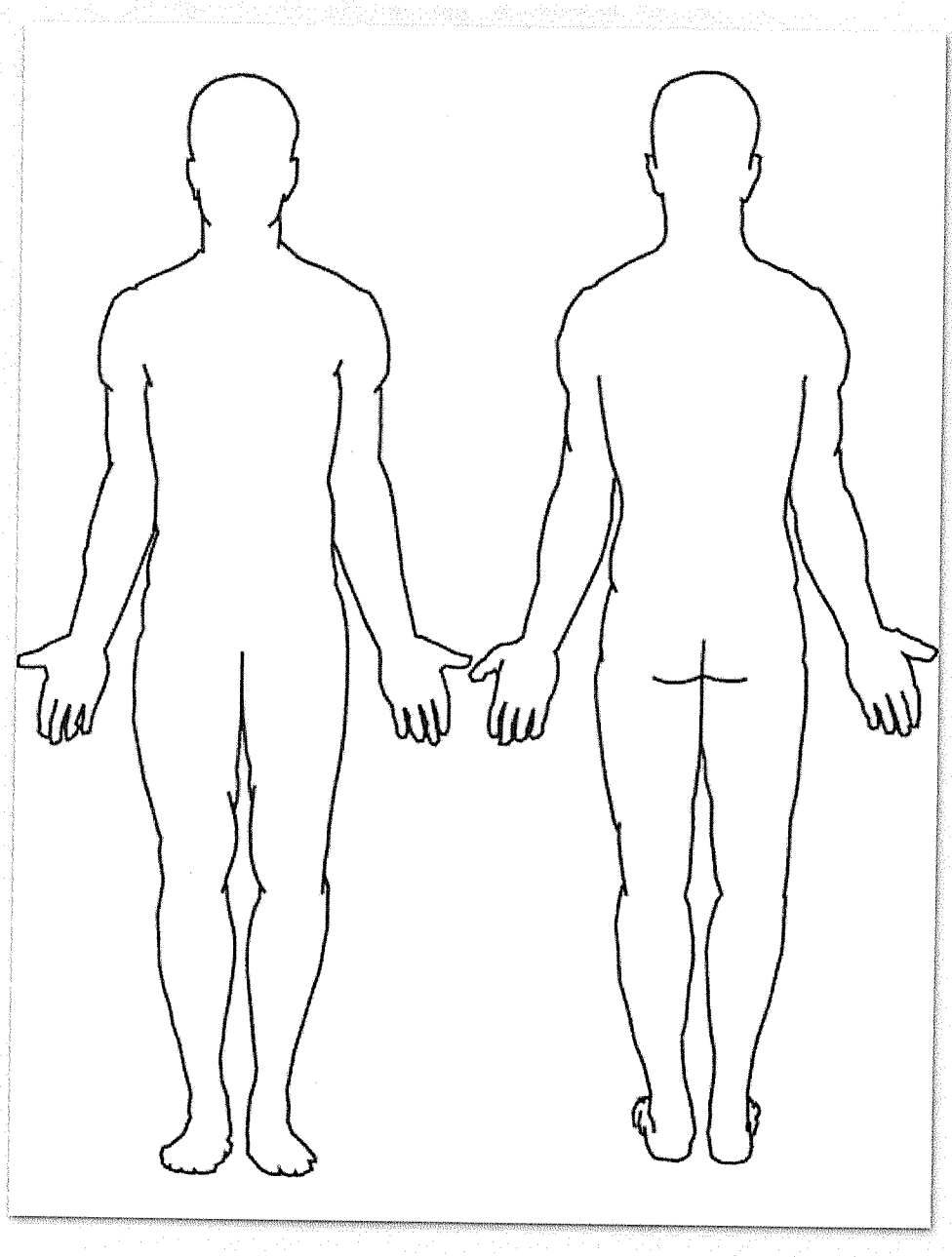
Please indicate on the image where your number ONE pain or problem area is located:



FRONT BACK

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Cancellation and No Call/No Show Policy

Revised: January 10, 2018

Case Physical Therapy was established in March of 1995, to provide the utmost personal care for our patients' physical therapy and rehabilitation needs. In the event that it is necessary for an appointment to be rescheduled or cancelled, we require a **24-hour** or **ONE** business day notice. This allows for another patient in need of care to be scheduled. In the event that a Monday appointment must be cancelled, we will need notice by Friday (one business day) in order to schedule another patient in that time slot.

In the event that a patient Cancels with less than a 24-hour notice, or No Call/No Shows an appointment, it is our policy to charge the patient a cancellation fee of **$100**. The patient is responsible for payment, NOT Medicare or Commercial Insurances.

To obtain the maximum benefit from your program, it is imperative that you attend and fully participate in all sessions and activities scheduled. Please try to limit your cancellations since it may prolong your rehab time. We try to stress that we have this policy in place because we have many patients waiting to get in. If you must cancel, we need plenty of time to give another patient your appointment time.

Please verify that you understand your financial responsibility by signing and dating this form.

Patient Signature: _____ Date: _____

Staff Initials: _____ Date: _____

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Notification of Patient Responsibility for Co-Payment/Co-Percentages and Deductibles

Your insurance company requires Case Physical Therapy, Inc. to collect your co-payments/co-percentages and any unmet deducible amounts from you at the **time of service**. If we do not collect these amounts, we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. Please bring a form of payment each visit. We accept Visa, MasterCard, personal checks, and cash (exact change, no cash box onsite).

Case Physical Therapy, Inc., has verified Out Patient Physical Therapy benefits based on the information furnished to us by you. Your insurance company has the disclaimer that this is a verification of benefits, NOT a guarantee of payment. Based on the information your insurance company provided to us, the amount that you are responsible for is as follows:

Co-Payment: _____
Co-Percentage: _____ **Insurance**: _____IN/OUT network
Deductible: _____ Deductible Amount Remaining: _____
Maximum visits/days/modalities: _____ Per person/condition/year/lifetime
Maximum Dollar Amount: _____ Out of Pocket Maximum: _____
Other Benefit Information: _____
_____

NOTE: **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. The estimation is based on a negotiated contract and any remaining balance will be billed to you after additional information is received from your insurance company.

You may receive statements from us during and after your treatment. This is to keep you informed of the amount billed to your insurance company. Due to the timing of processing your payments, **some statements may not reflect all payments paid by you to date**. In these cases, subsequent statements will reflect those payments.

Please verify that you understand your financial responsibility by signing and dating this form. Please let us know if we can assist you in any other way. Thank you.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

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Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Case Physical Therapy, Inc. to furnish medical care and treatment to: _____ (print patient name) that is considered necessary and proper in treating my physical condition.

Patient Signature: _____ Date: _____

Benefit Assignment/Release of Information

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare and private insurance to Case Physical Therapy, Inc. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient Signature: _____ Date: _____

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made TODAY. If your insurance carrier does not remit payment within 45 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit it to Case Physical Therapy, Inc.

I understand and agree that if I fail to make any payments for which I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Please verify that you understand your responsibilities by signing and dating this form.

I understand my responsibility for the payment of my account:

Patient Signature: _____ Date: _____

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Notice of Health Information Practices for Case Physical Therapy, Inc.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of your health record
- Amend your health record
- Obtain a log of disclosures of your health information
- Revoke your authorization to use and disclose information except to the extent that action has already been taken

Examples of Disclosure for Treatment or Payment

We are a HIPAA compliant clinic here at Case Physical Therapy.

- Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine course of treatment and outcomes achieved. We will also provide your referring physician with copies of various reports that should help in assisting him/her in your care
- We will use your health information for payment and the charges sent to you or a third-party payer may include information that identifies you, as well as your diagnosis, and procedures.
- Health professionals, using their best judgment, may disclose health information to a family member, or other relative, or any other person you specifically identify relevant to your involvement in your care or payment related to your care.

Please verify that you understand your responsibility by signing and dating this form.
I have read and understand the Health Information Practices as listed above.

Patient Signature: _____ Date: _____

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What to expect at your first visit

Please arrive for your first visit **15 minutes before your scheduled appointment time.** Upon your arrival, you may be asked to complete a few forms. This takes some time, so arriving early will ensure that your appointment will start on time.

Our staff will provide you all the necessary forms and will be available to assist you at any time. You will also be asked for the following:

1. Your insurance card(s). This is necessary to be able to bill your insurance.
2. Driver's License or photo ID.
3. **The physician referral for rehabilitation (as required to file insurance). We will NOT be able to treat you without it.**
4. Any applicable co-payment or deductible.
    - We accept Visa, MasterCard, personal checks, and cash.
5. The authorization form from your insurance company (if required by your insurer).

Once the paperwork is complete, your therapist will greet you. At Case Physical Therapy, you should expect to begin each visit without significant delay. Your initial evaluation will consist of an interview and a physical examination. The physical exam may only take 10 minutes, or last a full hour. The length of the exam depends upon your diagnosis and the extent and complexity of the injury and symptoms.

You may be asked to change into a gown or shorts to allow the therapist to best complete the necessary procedures. You may want to bring your own shorts if you anticipate being asked to change. Every physical examination consists of palpation and a variety of manual tests to assess strength, range of motion, joint mobility, pain, and functional capacity. Once the evaluation is complete, your therapist will discuss the findings and describe the treatment plan. Time permitting, treatment will begin immediately following the evaluation. Typically, patients are provided a home program at the conclusion of the first visit.