Please explain how you heard about us?

SOURCE ONE Village Physical Therapy

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Patient Information

Name (Last, First, MI)			**Date**
Street Address	**City**	**State**	**Zip Code**
Home Phone ☐ Preferred ( )	**Work Phone** ☐ Preferred ( )	**Cell Phone** ☐ Preferred ( )	
SSN	**Date of Birth**	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered ☐ Other ________
Employer	**Work Phone**	**Email Address**	

Accident Info

Were you in an accident? Yes ☐ **No** ☐
WC ☐ Auto ☐ Personal Injury _____

If yes, please describe

Date of Accident:__________
Are you under LOP?________

Do you have PIP? Yes ☐ **No** ☐ **Claim #**________________ **IF yes, Adjuster Name and #:** ____________________

Attorney Name: ____________________ **Phone:**__________ **Contact person:**__________

WC Injury: Adjuster Name: ____________________ **Phone:**____________________

Financially Responsible Party

Is the patient the responsible party/guarantor? ☐ Yes ☐ No (Please complete guarantor's information below)

Primary Insurance Company	**Policy #**	**Group #**	**Subscriber's SSN**
Name of Subscriber (if other than patient)	**Employer of Subscriber**	**Date of Birth**	
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ____________	**Gender** ☐ Male ☐ Female	**Phone** ( )	

Emergency Contact

Emergency Contact Name		**Relationship to Patient**
Home Phone ☐ Preferred ( )	**Work Phone** ☐ Preferred ( )	**Cell Phone** ☐ Preferred ( )

Referral Info

Referring Physician's Name	**Physician's Phone # / Fax #** (if known) ( )

PCP Info

Primary Care Physician ☐ Same as Referring Physician above	**Physician's Phone # / Fax #** (if known) ( )

ELECTRONIC APPOINTMENT REMINDERS

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments. Where would you like to receive appointment reminders? (Check desired reminder(s) and list contact information) Please indicate if you would like Spanish Text by circling Espanol.

Email ____________________ **Text Message/ Espanol** ____________________ **Voice Message/Espanol**____________________

Appointment information is considered to be "Protected Health Information" under HIPAA. By my initials, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

X____(Initial) do NOT want Source One to send me electronic appointment reminders.

By signing below, I acknowledge that the information I provided is correct to the best of my ability. I hereby authorize Village Physical Therapy, Source One Rehab and its staff to use and disclose my personal health information, as necessary, for the purpose of obtaining medical treatment, facilitating the payment from third party payors for treatment and for normal business.

Patient's Signature ____ **Date** ______________

Staff Initials:_______

Name:________________________________ **Date:**_____________________

****It is essential that you provide accurate, comprehensive and truthful information. Some physical therapy modialities are not appropriate for all patients due to certain medical conditions. ****

Is your current condition due to an injury or accident?_____ **If yes, describe**:______________________

When did this problem start?___________ **Average pain level**:(1-10)_________**10 being worst pain imaginable*

Have you had any of the following tests for this condition? XRAY ☐ MRI ☐ CT ☐ INJECTIONS EMG

Does your pain interfere with routine activities: ☐ sleep ☐ work driving ☐ reaching ☐ exercise ☐ housework ☐ hobbies ________________________other

Are you working?_ NO __YES **Occupation**?________________ **Job demands**: sitting standing bending/lifting computer work reaching climbing stooping/crouching crawling other _________________

Have you RECENTLY noted any of the following (check all that apply)?

❑ difficulty maintaining balance while walking ❑ headaches ❑dizziness/lightheadedness ❑ shortness of breath

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ anemia
- ❑ asthma
- ❑ diabetes
- ❑ epilepsy/seizures
- ❑ cancer
- ❑ heart disease
- ❑ high blood pressure
- ❑ multiple sclerosis
- ❑ osteoporosis
- ❑ spinal fusion
- ❑ Parkinson's disease
- ❑ arthritis
- ❑ stroke
- ❑ pacemaker
- ❑ spinal cord stimulator
- ❑ History of DVT? If yes, are you currently experiencing any symptoms; i.e chest pain, dizziness, elevated heart rate, shortness of breath, unexplained leg pain? Yes____ No _____N/A____
- ❑ other________________

Height:__________________ **Weight:** _________________

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1.________________________ 2.________________________ 3.________________________

Do you drink? YES __ NO __ Drinks/Week_______

Do you smoke? YES NO ______ pack/day

Active hobbies? ___________________

Are you currently taking medications? Yes___ No____

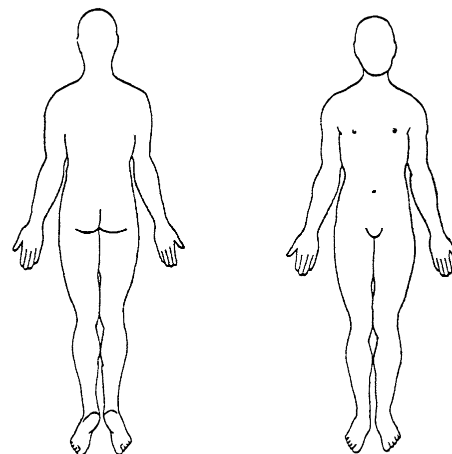
Please list current medications:____

❑ See Attached

ALLERGIES:

____

Please mark the location of your pain



What is your goal for therapy at this time?____

Patient Signature:___________________________________ **Date:**______________

SOURCE ONE 1 — Village Physical Therapy

Financial/Office Policy

Thank you for choosing us for your healthcare needs. We are committed to providing you with quality and affordable healthcare. The following is our financial policy. Please read it, ask us any questions that you may have, and sign the attached signature page. A copy will be provided at your request.

____ Initial **Patient Responsibility:** We participate in many insurance plans. We suggest you become familiar with your insurance benefits and confirm our participation with your plan. Most misunderstandings about insurance can be avoided if you understand what your policy covers. Please contact your insurance company with any questions you may have regarding your coverage. Pursuant to our participation with your insurance plan we are required to collect co-pays, deductibles, and coinsurance at the time of service. **These fees cannot be waived**. We accept cash, checks, Debit Cards, MasterCard, Visa, American Express, and Discover.

____ Initial **Third Party Liability:** I agree that payment for services rendered is not contingent upon any settlement judgment or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered in the event that a settlement is not reached or if my case is dropped by my attorney and I fail to contract with other legal counsel.

____ Initial **Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid driver's license and a current, valid insurance card. We may be required to collect payment in full if we are unable to verify your current insurance information. Please bring these items with you to each visit.

____ Initial **Claims submission:** If we are contracted with your insurance company, we will file your claims for you. Your insurance may require additional information from you in order to process the claim. Failure to comply with their request within 30 days will result in full patient responsibility for the claim. Please be aware that due to the length of time that is required to process payments it may be several months before you receive a statement for services.

____ Initial **Non-payment:** Unpaid accounts will be referred to an outside collection agency and will result in dismissal from the practice.

____ Initial **Returned Checks:** There will be a $25 fee for all returned checks.

____ Initial **No shows/ Cancellation Policy:** As a courtesy to our staff and other patients we ask that you keep your scheduled appointments. If you are unable to attend a scheduled appointment, please call and cancel at least two (2) hours prior to the appointment. Failure to cancel the appointment within the time frame will result in the assessment of a fee in the amount of $15 per incidence. **A missed Saturday appointment without cancellation notice will result in the assessment of a fee in the amount of $50 per incidence.**

ASSIGNMENT of BENEFITS

____ Initial **I authorize direct payment to be made to SOURCE ONE/VILLAGE PHYSICAL THERAPY, for any and all medical rendered. I hereby assign all of my right, title, and interest, to SOURCE ONE/VILLAGE PHYSICAL THERAPY of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of SOURCE ONE/VILLAGE PHYSICAL THERAPY customary charges for the services provided.**

______________________________ ______________

Print Patient Full Name Date

______________________________ ______________

Patient/Guardian Signature Date

Source1therapy.com

Staff Initials: __________

CONSENT for TREATMENT

______ **Initial** I acknowledge that the purpose of the care, reasonable alternative forms of therapy, risks of the recommended and alternative care and the risks of foregoing this care have been fully explained to and understood by me. I recognize that the practice of therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy. I also recognize that therapy care may involve the touching of my body by Therapist or other members of the Clinic's professional staff and that full or partial disrobing may be required to facilitate such care, all of which is expressly consented to by me. I agree to cooperate fully and to participate in all therapy care procedures, to comply with the plan of care as it is established and to pay Clinic's charges for such care upon my receipt of Clinic's invoice for such care. I have read the above and I certify that I have had an opportunity to discuss the contents thereof to my satisfaction. By initialing, I am hereby consenting to the therapy care described above, to be performed by Therapist or other members of Clinic's professional staff, as determined by Therapist from time to time.

HIPAA

_____ **Initial** I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice anytime. I have the right to review the notice prior to signing this consent. I have had the opportunity to receive and review the Notice of Privacy Practices of Source One.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information-Keeping information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient, referring physician, or legal guardian. The following names are people I would like to be involved in or have access to my protected health Information on a routine basis. I give permission for **SOURCE ONE/VILLAGE PHYSICAL THERAPY** to share my protected health information with:

______________________	______________________
Contact Name	Contact Name
______________________	______________________
DOB	DOB
______________________	______________________
Relation to Patient	Relation to Patient

RELEASE of INFORMATION

I hereby authorize **SOURCE ONE/VILLAGE PHYSICAL THERAPY**, to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment.

X ______ (Initial)

CONSENT and AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Consent for treatment, HIPAA Policy and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

______________________	______________________
Patient Name (Please Print)	Patient Date of Birth
______________________	______________________
Signature of Patient, Parent, or Legal Guardian	Date

Staff Initials: _________

Source One Therapy: Photograph, Video, and Satisfaction Survey Release

I hereby grant Syzygy and its affiliates permission to the rights of: my image; my likeness and sound of my voice as recorded on audio or video tape; my satisfaction survey responses, without payment or any other consideration. I understand that my image and my responses may be edited, copied, exhibited, published or distributed and I waive the right to inspect or approve the finished product wherein my likeness or satisfaction survey responses appear. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image, satisfaction survey responses, or recording. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

Photographic, audio or video recordings, and satisfaction survey responses may be used but not limited to following: social media and website enhancement, conference presentations, educational presentations or courses, informational presentations, on-line educational courses, educational videos, digital media presentation.

By signing this release, I understand this permission signifies that: photographic or video recordings of me; my satisfaction survey responses, may be electronically displayed via the Internet or in the public educational setting. I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby.

Full Name____

Phone______________________________________

Email Address____

Signature_______________________________________ Date____________________________

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature__________________________________ Date___________________________

If you do not wish for Syzygy and its affiliates to use your image; your likeness and sound of your voice as recorded on audio or video tape; your satisfaction survey responses; please initial below.

I reserve the right to withhold permission to the rights of my image; my likeness and sound of my voice as recorded on audio or video tape; my satisfaction survey responses.

X___________________________

Staff Initials: ______

GLEN ROSE MEDICAL CENTER

1021 HOLDEN ST
GLEN ROSE, TX 76043
254-897-2215

AUTHORIZATION, CONSENT AND AGREEMENTS

CONSENT TO TREATMENT: I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize diagnostic and therapeutic treatment considered necessary or advised in the judgment of the physician on duty. I understand that no guarantee of assurance has been made as to the results that may be obtained.

CONSENT FOR POST EMPLOYEE EXPOSURE TESTING: For the protection of our patients and employees, it is the policy of Glen Rose Medical Center Employee Health Services to request consent from source patients whenever possible to perform post exposure lab testing. By signing below, I consent to allow GRMC to perform basic testing to determine presence of Hepatitis and HIV should an employee or affiliated personnel encounter potential blood or body fluid exposure.

FINANCIAL AGREEMENTS: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay all reasonable attorney's fees and collection expenses.

ASSIGNMENT OF BENEFITS: I hereby authorize all insurance companies and government payers to pay directly to Glen Rose Medical Center, physicians involved in my/(the patient's) treatment and care, and any ancillary providers; any benefits and fees under my insurance policy/policies or government program of which I/(or the patient is an enrollee or beneficiary). I further authorize Glen Rose Medical Center and any ancillary providers to appeal any denial or partial denial of benefits on my/(the patient's) behalf. I understand that this order does not relieve me of my obligation to pay the account. In addition, any balance that is not covered or paid by the insurance company is my responsibility.

PERSONAL VALUABLES: It is understood and agreed that the hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs or garments and the hospital shall not be liable for loss of damage to any other personal property.

ANCILLARY BILLING: In addition to your bill from the hospital, you may receive a bill from the Surgeon, Anesthesiologist, Pathologist and Radiologist for the professional services.

RELEASE OF MEDICAL INFORMATION: I hereby consent and authorize Glen Rose Medical Center, their affiliates or their agents, to release any medical information in connection with the services rendered for determination of benefits, or for collection and said benefits from my health insurance carrier(s) and/or other parties responsible for payment.

CONFIDENTIALITY: I grant permission to Glen Rose Medical Center to acknowledge I am a patient in their facility. I wish to receive visitors. ☐ Yes, ☐ No.

ACKNOWLEDGMENT OF RECEIPT: I have received Glen Rose Medical Center's Notice of *"Privacy Policies and Practices."*

I HAVE READ THE AUTHORIZATION, CONSENT AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE. I ACKNOWLEDGE THAT I HAVE RECEIVED COPY OF THE ABOVE STATED DOCUMENTS BY MY SIGNATURE BELOW.

______________________________	__________	______________________________
Signature of Patient / Responsible Party / Relationship	Date	Patient's Name
______________________________	__________	______________________________
Witness Signature	Date	Patient Account