PHYSIOBACK
PHYSICAL THERAPY

New Patient Registration

Name: ______________________ Today's Date: ______________________

Address: ____

City: ______________ State: ________ Zip Code: ____________________

Phone (home) :______________________ cell: ______________________

May we leave messages at the numbers above? __Yes __No

Date of birth: ________/_________/_____________

Email address:____

Referring Physician: ____

Referring physician phone:____

Referring physician fax ____

Name of person we should contact in case of emergency:____________________

Phone number: ____________________________________

Relationship to you: ____________________________________

How did you find out about our practice? ______________________________

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Patient Insurance Worksheet

We do not participate in any insurance networks. We will, however, offer guidance on how to manage your out-of-network benefits. We suggest that prior to your first visit you contact your insurance company to confirm your coverage benefits. This form serves as a checklist to help you get all the necessary information in order to maximize your reimbursement.

Patient Name:____

Primary InsuranceCompany:____

Insurance ID#: ____________________Group #:_________________________

Plan Type:_________________________ Insurance Tel#:_______________________________

Insurance effective date: _________/_________/__________________

Name of person you are speaking with: _____________________ID:________________________

Time of Day:___________Tracking ID for the call:______________________________________

How much is my out-of-network deductible? $____

Is there Individual vs. Family deductible? Yes / No $______________________________________

How much of my deductible has been met? $____

What is my co-insurance percentage? 10% 20% 30% 40% Other %___________________________

Does my policy require pre-certification (like ORTHONET) for physical therapy services? Yes/ No

If yes, Pre-Cert Phone #:________________ Pre-Cert Authorization #:__________________

Number of sessions allowed with this Pre-Cert:____________

Expiration Date? Yes / No _________/_________/_________________

How many out-of network physical therapy visits do I have? _____ Visits per yr_____

per year/per lifetime__________ per condition/per year_______

Is there a maximum amount/cap that my plan pays for out-of-network physical therapy? Yes/No $________

Number of PT visits used already this year:________

Secondary Insurance:_________________Secondary Insurance ID#:______________

Secondary Insurance Tel#:__________________________________

Effective date: __/__/____Deductible:_________ Co-Insurance payment:_____________

I understand that I am responsible to obtain accurate information about my insurance policy in order to maximize my benefits. I also understand that I will pay for services at the time they are rendered and it will be my responsibility to seek reimbursement. Prana Physical Therapy, will provide documentation, such as evalutions and progress notes to assist you in this process.

Signature: ______________________________________ Date: __________________

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Outpatient Physical Therapy Medical Intake Form

Name: ______________________________Male___ Female__ Height: ______ Weight: ________lbs

Occupation: ___________________________ General Health: Excellent___Good___Fair___Poor___

Diet: ____

Exercise: ____

Smoking: Yes / No Alcohol: Yes / No If yes, how many drinks per day___ per week___ occasional___

Medical conditions: ____

Medications: ____

Assistive Devices: None___ Cane___ Walker___ Hearing aids___ Glasses___

Other:____

Past Injuries/Surgeries with dates:____

____

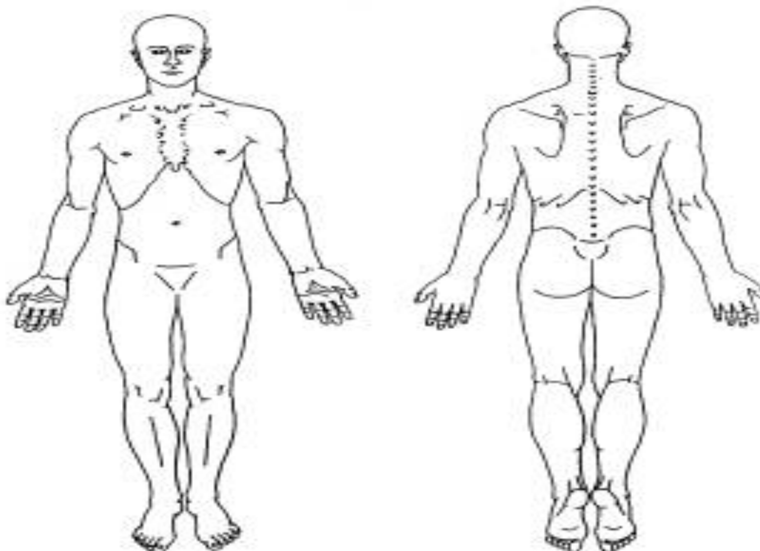
Medical Tests: X-ray___ MRI___CT scan___Bone density___ EMG___Blood test ___Urinalysis___ Other Tests/Results:

____

Current condition(s)/ symptoms: ____

Pain level in the last couple of days (circle): No pain Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10

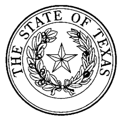


Where is your pain located?

How would you describe the pain? Dull Achy Sharp Numb Tingling

When did your symptoms start? ________/________/________

How did your symptoms develop? Injury (explain): ____________________________date: ____/____/____



Texas Board of Physical Therapy Examiners

333 Guadalupe, Ste 2-510 ***512/305-6900 • 512/305-6951 fax***
Austin, Texas 78701-3942 ***http://www.ptot.texas.gov***

Physical Therapy Treatment without Referral Disclosure

Please read carefully and acknowledge below:

I understand that physical therapy treatment without a referral will be based on the physical therapist's examination and evaluation of my current condition which may result in identification of movement and mobility dysfunction.

I understand that the physical therapist will not diagnose an illness or disease, and that physical therapy is not a substitute for a medical diagnosis.

I understand that if a medical diagnosis has already been established by a qualified healthcare practitioner, the physical therapist will take it into consideration during the evaluation process.

I understand that the physical therapy plan of care developed by the physical therapist may not be based on radiological imaging.

I understand that if images have previously been obtained, the physical therapist may use the information as part of the evaluation process.

I understand that if the physical therapist identifies a need for radiological imaging, the physical therapist may recommend that radiological imaging be obtained.

I understand that my health insurance may not cover physical therapy services if provided without a referral from a qualified healthcare practitioner.

I acknowledge that I have received the above disclosure.

Patient Name (print): ____

____ ____________________
Signature of Patient or Legal Representative Date

____
If Signed by Legal Representative, Print Name and Relationship to Patient

Approved by the Texas Board of Physical Therapy Examiners – 10/11/2019
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OFFICE POLICIES AND PROCEDURES

Welcome and thank you for choosing Physioback Physical Therapy for your Physical Therapy need.

CONSENT TO TREATMENT

Physioback Physical Therapy is a hands-on Physical therapy clinic. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that ae published or otherwise publicly known. Forms of deep tissue massage, therapeutic exercise programs, neuromuscular re-education as well as other treatment modalities may be used.

The number of treatments needed and recovery time can vary widely due to the age of injury, number of times injured, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at Physioback Physical Therapy, LLc and I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

PAYMENT AGREEMENT

Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third party interest or the resolution of any legal action or lawsuits in which you may be involved.
- **Out of Network Policy.** Physioback Physical Therapy is a fee for service clinic. This means that Physioback Physical Therapy is not in network with any private health plans. Payment is due at the time of service and we will not bill your insurance company.
- We can, upon request, provide receipts with diagnosis and treatment codes which you may submit to your private insurance company. Such receipts cannot be made available if you are a Medicare beneficiary
- **Medicare Policy.** If you are a Medicare beneficiary, you understand that our licensed physical therapists are not enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since the documentation and administrative processing of our services are not designed to meet Medicare's covered

benefit requirements and we are not Medicare enrolled providers, our services will not be covered paid in full or in part by Medicare even if the same services might be considered covered benefits when provided by a Medicare enrolled provider.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE WRITTEN STATEMENTS AND PAYMENT TERMS.

____

Patient/legal guardian signature Date