

**Confidential Medical History****Arlington Physical Therapy**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Can you receive texts at this number?  Yes  No

Alternate Phone: \_\_\_\_\_ Email: \_\_\_\_\_

How would you like to receive appointment reminders?  Text  Call  EmailHeight: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: Male  Female 

What caused your current problem? \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Current Symptoms: Pain  Numbness  Stiffness  Other: \_\_\_\_\_Pain Level(0 = no pain, 10 =worst pain): \_\_\_\_\_ Condition: New  Chronic Have you had any of the following for this injury? None  MRI  X-Ray  Other: \_\_\_\_\_**Do you or have you ever had any of the following?**Asthma, Bronchitis, Emphysema: Yes  No  Arthritis/Swollen joints: Yes  NoShortness of Breath/Chest Pain: Yes  No  Osteoporosis: Yes  NoCoronary Heart Disease: Yes  No  Varicose Veins: Yes  NoDo you have a Pacemaker? Yes  No  Gout: Yes  NoEmotional/Psychological Problems: Yes  No  Sleeping Difficulties: Yes  NoHeart attack: Yes  No  High blood pressure: Yes  NoStroke/TIA: Yes  No  Dizziness or Faintness: Yes  NoBlood Clot/Emboli: Yes  No  Are you pregnant? Yes  NoEpilepsy/Seizures: Yes  No  Anemia: Yes  NoThyroid trouble/Goiter: Yes  No  Type 1 Diabetes: Yes  NoInfectious Disease: Yes  No  Type 2 Diabetes: Yes  NoCancer or Chemo/Radiation: Yes  No  Bowel/Bladder Problems: Yes  NoSevere/Frequent Headaches Yes  No  Vision/Hearing Difficulties: Yes  NoSmoking: None  Daily  Weekly Alcohol Consumption: None  Daily  Weekly

Please list any allergies: \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_Please list any previous surgeries with the date: \_\_\_\_\_  
\_\_\_\_\_How did you hear about us? Friend  Family  Website  Doctor  Other 

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand I am responsible for any charges not covered by my insurance carrier. Furthermore, I understand I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Arlington Physical Therapy regardless of participation in or out of network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Letter of Consent****Arlington Physical Therapy**

I hereby authorize Arlington Physical Therapy, P.C. to release any medical information necessary to process the claims and furnish information to insurance carrier(s) concerning my treatment and hereby assign to the therapist(s) all payments for services rendered.

I understand I am responsible for all allowable charges my insurance company does not pay.

I understand by signing I am giving my permission for treatment.

I authorize Arlington Physical Therapy, P.C. to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

I authorize the staff of this facility to say I am present or not present at this facility and provide information about my general condition to those persons listed below who are personally interested in my whereabouts and progress. I agree to have my next of kin as listed below notified in case of injury, illness, or emergency.

Name of Next of Kin	Telephone	
Address		
City	State	Zip Code

Name(s) of Interested Persons	Relationship

I permit a copy of this authorization to be used in place of the original.

I understand this consent may be withdrawn by me, in writing, except to the extent authorized information has been disclosed in reliance upon it. In any event, this consent shall expire one (1) month after my discharge from this facility. I also understand any disclosure made on my behalf by this facility is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

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Signature

Printed Name

Date

SIGN AND DATE

**TO OUR VALUED PATIENTS:**

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Copayments, coinsurances, and deductible allowable, if any, are due on each visit for charges incurred during your visit. We accept cash, checks, MasterCard, Visa, AMEX, and Discover. We bill electronically to expedite payment of claims whenever possible.

**Please read carefully:**

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard, and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.
4. **Medicare patients are responsible for their deductible and 20% of service charges (Medicare Fee Schedule Pricing for Tarrant County). Medicare recipients please sign below.**

Signature

Printed Name

Date

SIGN AND DATE

5. For liability or where another party is responsible and worker's compensation cases, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection must be received from your attorney before your treatment. For worker's compensation, the name of the adjuster, telephone number, and claim number is needed before your treatment. Without this information, you become responsible for the account in full.
6. Please understand attendance is vital to achieving your wellness goals. Our office requires a 24-hour notice for cancellation of appointments. You can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to reschedule. However, there will be a \$50.00 fee for a missed appointment without proper notification to the office.
7. There will be a \$25.00 fee for medical records less than 50 pages. For any medical records more than 50 pages, there will be a \$50.00 fee.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility for the date the services are rendered. We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I have read the above policies and agree.

Signature

Printed Name

Date

SIGN AND DATE

## Health Information Privacy Notice

## Arlington Physical Therapy

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

### **1. About Protected Health Information "PHI"**

In this notice, "We", "Our", or "Us" means Arlington Physical Therapy, P.C. and our workforce of employees and volunteers. "You" and "You're" refer to each of our patients who are entitled to a copy of this notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulation requires us to protect health information about you in the manner we describe here. Certain types of health information may specifically identify you. Because we must protect this health information, we call this Protected Health Information or "PHI". In this notice we will tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or with a complaint

### **2. Some of the Ways We Use or Disclose Your Protected Health Information**

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care. We are allowed to use or disclose your PHI for certain activities we call "health care operations". Health care operations involve many administration, education, and quality of assurance activities in our facility. We will give you examples of each of these to help explain them, but space does not permit a complete list of all uses or disclosures. For this reason, you may ask us questions.

#### **Treatment**

We use and disclose your PHI during your treatment. For example, you are evaluated by a physical therapist. The information is then shared in a report with your doctor. We may also use or disclose your PHI for many other types of treatment activities.

#### **Payment**

After we treat you, we will ask your insurer to pay us. We may type some of your HI into our computers and send a claim to your\_insurer. Here, we use your PHI to tell your insurer what type of health problem you had and what we did to treat you. Your\_insurer may ask us to give them your membership number in your employer's health plan or your insurer may want to review your medical records to be sure your care was necessary. When we use and disclose your PHI in this way, it helps us get paid for your care and treatment.

#### **Health Care Operations**

We also use and disclose your PHI in our health care operations. For example, our therapists meet periodically to study medical\_records to monitor the quality or care in our facility. Your medical records and PHI could be used in these quality assessments. Sometimes, we train physical therapists in our facility and use the PHI of real patients to test them or their skills. Other\_operational use or disclosures may involve business planning of our facility or resolution of a complaint.

#### **Social Uses**

We also use or disclose your PHI for purposes involving your relationship to us as a patient. We may use or disclose your PHI to:

- Remind you of your appointment with us for treatment
- Tell you about treatment alternatives and options
- Tell you about our health benefits and services

#### **Your Authorization May Be Required**

In many cases summarized here, we may use or disclose your PHI either with your consent or as required or permitted by law. In all other cases, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you later change your mind, you may revoke your authorization.

### **3. Certain Uses and Disclosure of your PHI Required or Permitted by Law**

Many laws and requirements apply to us that affect your PHI. These laws and regulations may either require us or permit us to use or disclose your PHI. From the federal health information privacy regulations, here is a list describing required or permitted uses and disclosures.

- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself
- If we receive certain assurances that protect your privacy, we may use or disclose your PHI for research

We may also use or disclose your PHI:

## **Health Information Privacy Notice**

## **Arlington Physical Therapy**

- When required by law. For example, when ordered by a Court to turn over certain types of your PHI, we must do so.
- For public health activities such as reporting an adverse drug reaction to the Food and Drug Administration
- To report neglect, abuse, or domestic violence
- To the government proceeding such as in a response to a valid subpoena
- In judicial or administrative proceedings such as in response to a valid subpoena
- When properly requested by law enforcement officials
- If we reasonably believe to do so will avert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
- In connection with certain types of organ donor programs

### **4. Your Privacy Rights and How to Exercise Them**

You have specific rights under our federally required privacy program. Each of them is summarized here.

#### **You're Right to Request Limited Use or Disclosure**

You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request, we must abide by that agreement.

#### **You're Right to Confidential Communication**

You have the right to receive confidential communications from us at a location you provide. We require that you make your request in writing, provide us with the address, and explain to us if the request will interfere with your method of payment for your care.

#### **You're Right to Revoke Your Consent or Authorization**

If you have granted us your consent or authorization to use or disclose your PHI, you may revoke consent or authorization in writing. However, if we have relied on your consent or authorization, we may use or disclose your PHI to that extent.

#### **You're Right to Inspect and Copy**

You have the right to inspect and copy your PHI. We may refuse to give you access to your PHI if we think it may cause harm, but we have to explain why and give you someone to contact about our decision who will know how and when to get a review of our refusal.

#### **You're Right to Amend Your PHI**

If you disagree with what your PHI in our records says about you, you have the right to request in writing that we amend your PHI when it is in the record we create or have maintained for us. We are not required to respond to your request if the records you are asking about are not our records. We may refuse to make your requested amendment. Then, you will have the right to submit a written statement about why you disagree. If we still disagree, we may prepare a counter statement. Your statement and our counter statement must be made part of our record about you.

#### **You're Right to Know Who Else Sees Your PHI**

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years. You cannot ask for disclosures before August 10, 2010. We do not have to account for all disclosures, including those involving treatment payment and health care operations as described above. There is no change for an annual accounting but there may be for additional accountings. We will tell you if there is a charge for your accounting and you will have the right to withdraw your request, or pay to proceed.

#### **Your Rights to Complain**

If you believe your privacy rights have been violated, you have the right to make a complaint to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint, you should submit it in writing to the contact person identified in this notice (below 6). Your complaint should provide a reasonable amount of specific detail to enable us to investigate a potential problem.

### **5. Some of Our Privacy Obligations and How We Perform Them**

We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you notice of our privacy practices. This document is our notice. If you did not get a paper copy of this notice, you may have one. We will abide by the privacy practices set forth in this notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us.

### **6. Contact Information**

If you have any questions about this notice, or if you have a complaint, please contact:

Name: Ana Maria Madrid, PT      Title: Privacy Officer      2310 W I-20 Suite 204      (817) 466-7276

Signature

Printed Name

Date

SIGN AND DATE

## NOTICE

Federal Law protects the confidentiality of the patients of this facility. It is unlawful to disclose any information about a patient, even their name to anyone. By signing into the facility you agree to abide by these Federal Laws and not disclose any information or the identity of anyone here.

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Signature

Printed Name

Date

SIGN AND DATE



**Rights**

1. You have the right to dignified and respectful care.
2. You have the right to know about and understand your physical condition.
3. You have the right to obtain any information requested by you to give informed consent before any treatment and /or procedure.
4. You have the right, at your own expense, to consult with another physician or specialist.
5. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal.
6. You have the right to be treated in a safe environment free of physical and psychological threats.
7. You have the right to privacy regarding visitors, mail, and/or telephone conversations.
8. You have the right to expect that all communications and records regarding your care will be held confidential.
9. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice.
10. You have the right to communicate verbally or in writing with anyone outside the practice and to expect that an interpreter will be provided if language is a barrier.
11. You have the right to know the identity, professional status, and institutional affiliation of anyone treating you.
12. You have the right to request an itemized statement of all services provided to you through this practice.
13. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.
14. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

**Responsibilities**

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.
2. You are responsible for participating in the development of your plan of care.
3. You are responsible for attending scheduled therapy and participating in activities prescribed by your treatment plan.
4. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice. You are responsible for following practice rule and regulations.

**Concern/Complaint Procedure**

We want to hear from you if you have any concerns, complaints, or compliments regarding your stay treatment and care in our practice. Please inform any staff member. Response to a concern/complaint will take place within 24 hours. Concerns/complaints will be monitored and the information utilized to improve our program.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.

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Signature

Printed Name

Date

# **Attention All Patients**

You will be responsible  
for a \$50.00 fee if you  
miss an appointment or  
fail to cancel your  
appointment without  
24-hour notice!

*Thank you for your understanding,*  
Arlington Physical Therapy

Please sign below stating you understand the policy:

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Signature

Printed Name

Date