



6049 W Interstate 20
Arlington, TX 76017
Phone: 817-483-1746
Fax: 817-483-5874

PATIENT CONSENT

CONSENT FOR TREATMENT: I voluntarily consent to medical treatment provided at this facility. I acknowledge that physical therapy intervention will involve palpation, a physical examination, and possible pain provocation. I understand that my pain may increase at times as a result of the evaluation and treatment. I further understand that I may refuse any treatment at any time.

Initial: _____ Date: _____

TREATMENT OF MINORS: I, as a parent or legal guardian of a minor, do hereby consent to the treatment of my minor child under the plan of care created by the treating clinician. I understand and consent that treatment under this plan may be provided in my absence on subsequent visits.

Initial: _____ Date: _____

FINANCIAL POLICY: I do hereby consent to the release of protected health information as needed to process my medical claims. I assign all benefit payments for services provided by Therapy Excellence to this facility. I understand that I am responsible for copayments, coinsurance, deductibles and other services not covered by my medical insurance company.

Initial: _____ Date: _____

LIABILITY: I acknowledge that I have been advised to leave my personal valuables at home and do hereby agree that this facility is not responsible for loss or damage to personal items while I am attending therapy sessions.

Initial: _____ Date: _____

NOTICE OF PRIVACY: Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Therapy Excellence cannot and does not release its patients' protected health information (PHI) without the express written consent of the patient, except as otherwise authorized or required by law to disclose such information. I understand that my personal PHI will be provided to my physicians who refer me to Therapy Excellence for treatment, other physicians I designate to receive my information, the insurance company or employer making payment for services rendered, and any individuals I specifically designate with written consent. Other than those specified above and as otherwise required by law, my medical and demographic information will not be given to any persons or entities without my express written consent for any purpose. I hereby give my consent to release my PHI, including medical information, billing information, and appointments, to the persons I have designated below. I understand that, except as explained above, the individuals listed below are the only persons to whom Therapy Excellence may disclose my PHI.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____



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CANCELLATION POLICY

At Therapy Excellence we pride ourselves in providing quality care on each treatment session. Same day cancellations make it impossible for us to schedule in this manner. For this reason, we respectfully request that you provide us with 24 hours' notice if you will be unable to keep a scheduled appointment. We understand that life happens-family crises, illnesses, work, etc. For this reason, we will allow one cancellation or reschedule with less than 24 hours' notice without a penalty. Any subsequent same day cancellations, reschedules or no show visits will result in a \$25 fee regardless of the reason for cancellation or reschedule. We do have voicemail and e-mail if you need to reach us outside of standard operating hours. Please call (817) 483-1746 to leave a voicemail or e-mail frontdesk@therapyexcellenceinc.com prior to 7 a.m. on the day of your appointment to avoid the cancellation fee.

Your signature indicates that you are aware of this policy and willing to comply.

Name: _____ Signature: _____ Date: _____

TEI Witness: _____

Who can we thank for your referral to our office?

Past Patient Family/Friend Doctor Insurance Company Social Media/Ad Free Screen

Below are 7 insurance related questions. Insurance companies require us to verify that they are the responsible party. Please answer the questions below so that we may verify that there is not another primary payer.

Date of injury: _____

Are you currently receiving home health services? Yes No

Are you currently receiving any other therapy services? Yes No

Do you anticipate litigation due to your injury? Yes No

Is this injury the result of a fall at an establishment? Yes No

Is this injury the result of an auto accident? Yes No

Is this injury the result of a school-related injury? Yes No

If Yes, which school? _____

Signature: _____ Date: _____



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APPOINTMENT REMINDER CONSENT

Complete this form and sign below to give your permission for Therapy Excellence to provide automatic appointment reminder service by e-mail or by cell phone text message. We can only send reminders by one method.

Step one: Select one option below

- Therapy Excellence may send e-mail messages to confirm my upcoming appointments to _____
- Therapy Excellence may send cell phone text messages to confirm my upcoming appointments to _____

Step two: If you would like text messages instead of e-mail reminders, please indicate your cell phone carrier below.

- ALLTel
- AT&T
- Boost Mobile
- Cingular
- Cricket Wireless
- Metrocall
- MetroPCS
- Nextel
- Qwest
- Sprint PCS
- T Mobile
- US Cellular
- Verizon
- Virgin Mobile

Signature: _____ Date: _____



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MEDICAL HISTORY

What is your child's date of birth? _____

If your child is less than 3 y/o, please complete the **BIRTH HISTORY**:

Pregnancy Complications: _____

Weeks Gestation at Delivery: _____ Type of Delivery: Vaginal / C Section / Forceps Used

Delivery Complications: _____

Does your child have any of the following medical conditions?

- | | | |
|---|---|---|
| Y | N | Asthma/Other Breathing Disorder |
| Y | N | Arrhythmia/Cardiac Condition |
| Y | N | Cancer |
| Y | N | Stroke/Cerebral Palsy/Traumatic Brain Injury |
| Y | N | Autism Spectrum Disorders |
| Y | N | Unexplained Weight Loss or Gain |
| Y | N | Anxiety/Depression/Emotional or Psychological Condition |
| Y | N | Headache/Migraine/TMJ |
| Y | N | Seizure Disorder |
| Y | N | Hepatitis/HIV |
| Y | N | Developmental Delay |
| Y | N | Fracture |
| Y | N | Diabetes |
| Y | N | Balance Difficulty/Falls |
| Y | N | Neurological Disease |
| Y | N | Vision/Hearing/Speech Disturbance |
| Y | N | Are you allergic to latex? |
| Y | N | Are you allergic to adhesive/tape/band-aids? |
| Y | N | Do you use tobacco? |

At what age did your child achieve the following motor milestones:

Rolling: _____ Sitting: _____ Crawling: _____

Walking: _____

Has your child had any surgeries? _____

What is your goal with treatment? _____

Does your child have siblings in the household? Y N Ages: _____

Signature: _____ Date: _____ Therapist Initials: _____