Phone: 817-483-1746
Fax: 817-483-5874

PATIENT INFORMATION

Name:	Date of Birth:	Gender: Male / Female
Address:	City:	State/Zip:
Social Security#:	Mobile Number:	Home Phone:
Email:	Single / Married / Widowed / Divorced	
Emergency Contact/Relationship:	Phone Number:	

PRIMARY INSURANCE

Insurance Name:	Primary Insured:
Relation:	Date of Birth (If not self):
Policy#:	Group Number:

SECONDARY INSURANCE

Insurance Name:	Primary Insured:
Relation:	Date of Birth (If not self):
Policy#:	Group Number:

Work Comp/Injury

WC/Auto Date of Injury:	Adjuster:
If WC, Employer Name:	Employer Address:

We can provide automated appointment reminders via e-mail for your convenience.
Please INITIAL one option below.

I consent to receive automatic appointment reminder e-mails from Therapy Excellence

________ No

________ Yes, at _______________________________________@________________________.com

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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 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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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: ___________