Dear Patient,

We are very excited to welcome you to Promotion Physical Therapy! We want you to know how much we appreciate the opportunity to be your physical therapy provider. Our team is focused on promoting the physical well-being of every patient by providing the highest quality of care in a positive, loving, and encouraging environment.

During your first appointment, the physical therapist will examine you based on the prescription written by your doctor and make an assessment of your physical condition. They will explain their findings and the appropriate treatment for your condition to you. Then your treatment will begin so we can get you back to the things you love ~ faster!

While being treated by our team, please do not hesitate to ask questions, make comments, and share your concerns so that we may make your physical therapy treatment as successful as possible. Be sure to wear comfortable clothes and shoes. You may want to bring water to keep yourself well hydrated during your treatments.

Enclosed you will find a New Patient Packet. Please complete all the forms and return them to the front office personnel, along with your photo identification and your health insurance card(s) if applicable.

Thank you for choosing Promotion Physical Therapy! We look forward to serving you.

Sincerely,

Promotion Physical Therapy, P.C.

Visit us at:
www.promotionpt-sa.com

North Central: 16530 Huebner Road, Ste. 119, San Antonio, Texas 78248	O: (210) 479-3334 F: (210) 479-3338
Westover Hills: 10415 State Highway 151, Ste. 101, San Antonio, Texas 78251	O: (210) 647-9970 F: (210) 647-7229
Medical Center: 4944 Research Drive, San Antonio, Texas 78240	O: (210) 478-5486 F: (210) 478-5388
Stone Oak/TPC: 3111 TPC Parkway, Ste. 112, San Antonio, Texas 78259	O: (210) 257-8272 F: (210) 259-8482
Boerne: 904 East Blanco Road, Boerne, Texas 78006	O: (830) 331-1114 F: (830) 331-1124

PATIENT INFORMATION:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____/_____/_____ Social Security Number: _____Gender: _____

Address: _____City/State/Zip: _____

Preferred contact number: Home / Mobile Home:(_____) _____ Mobile:(_____) _____

Marital Status: _____ Occupation:_____ Email Address: _____

EMERGENCY CONTACT INFORMATION:

First Name: _____ Last Name: _____ Phone: (_____) _____

REFERRING PHYSICIAN:

Name: _____ Phone: (_____) _____

ADDITIONAL INFORMATION:

1. Is this a work-related injury? Yes No If so, what was the date of the injury? _____

   Employer Name & Phone Number: _____

   Adjuster Name & Phone Number: _____
2. Are you being referred to physical therapy due to a Motor Vehicle Accident? Yes No
3. Is this case involved in litigation? Yes No

   If so, please list your attorney's name and phone number below:

   _____
4. Have you received any physical therapy for any condition this year? (circle) Yes No

   If so, how many visits? _____
5. In the current calendar year, have you received or are you currently receiving **any Home Health Services such as PT, OT, ST, Social Worker, Aide, Nurse, Durable Medical Equipment**? (circle) Yes No

   If so, please list your Home Health Agency's name and phone number below:

   _____
6. Have you had surgery for this condition? (circle) Yes No

   If so, what was the date of the surgery? _____
7. How did you hear about Promotion Physical Therapy? Doctor Friend Mail Social Media

   Other: _____

PRIMARY HEALTH INSURANCE:

Primary Insurance Provider: _____ Insurance ID #: _____

Policy Holder First and Last Name: _____

Policy Holder Date of Birth: _____ / _____ / _____ Policy Holder SSN: _____

Relationship to Patient: _____

SECONDARY HEALTH INSURANCE (if applicable):

Secondary Insurance Provider: _____ Insurance ID #: _____

Policy Holder First and Last Name: _____

Policy Holder Date of Birth: _____ / _____ / _____ Policy Holder SSN: _____

Relationship to Patient: _____

TERTIARY HEALTH INSURANCE (if applicable):

Tertiary Insurance Provider: _____ Insurance ID #: _____

Policy Holder First and Last Name: _____

Policy Holder Date of Birth: _____ / _____ / _____ Policy Holder SSN: _____

Relationship to Patient: _____

For Office Use Only:
Intake completed by: _____ Date: _____

PAST MEDICAL HISTORY:

1) Please check "**Yes**" or "**No**" to all the medical conditions listed below that you are currently diagnosed with or have been previously diagnosed with:

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	High Blood Pressure
☐	☐	Bipolar Disorder	☐	☐	HIV / AIDS
☐	☐	Bowel/Bladder Problems	☐	☐	Osteoarthritis
☐	☐	Bronchitis	☐	☐	Osteoporosis
☐	☐	Cancer	☐	☐	Pneumonia
☐	☐	Chest Pain	☐	☐	Rheumatoid Arthritis
☐	☐	Depression	☐	☐	Shingles
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Emphysema	☐	☐	Are you currently pregnant?
☐	☐	Epilepsy/Seizures	☐	☐	History of alcoholism?
☐	☐	Fibromyalgia	☐	☐	History of drug abuse?
☐	☐	Heart Disease/Attack	☐	☐	Currently have surgical implants?
☐	☐	Hepatitis	☐	☐	Currently have a pacemaker?

2) Please list all the surgeries that you have had, including the approximate date:

_____

_____

_____

3) Please list any other medical conditions, past or present, which are not listed above:

_____

_____

_____

4) Do you smoke? Yes No

If you do smoke, please refrain from smoking for <u>2 hours before and 2 hours after</u> your physical therapy treatment. This will significantly improve your healing process.

5) Please mark the number below that corresponds to the worst pain you have had in the past week:

0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

No Pain — Moderate Pain — Severe Pain

Patient Name: _____

Signature: _____ **Date:** _____

MEDICATION LIST: A pre-printed copy may be provided in lieu of this form. Please ask the front office personnel if you require additional copies of this sheet.

Patient Name: _____ **Date:** _____

Medication Name	Dosage	Frequency	Route of Administration (oral, injection, nasal spray, etc.)
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			
21)			
22)			
23)			
24)			
25)			

I hereby acknowledge that I have completed this information to the best of my ability:

Signature: _____

Patient Health Questionnaire (PHQ-9)
Name:
Date:
DOB:

Instructions:

Complete this form if you are at least 12 years of age.
Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "√" to indicate your answer)

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		Add columns	+	+	
	(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	**TOTAL:**			

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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PATIENT AUTHORIZATIONS

Consent for Treatment and Authorization to Release Information

I hereby authorize Promotion Physical Therapy, P.C., to provide any physical therapy services or related services as deemed necessary by the physical therapist(s). I consent and authorize Promotion Physical Therapy, P.C., to release information contained in my medical and financial records, including diagnosis and test results to my referring physician, insurance company, worker's compensation adjuster, or an attorney's office if applicable.

INITIALS: _____

Consent to Treat a Minor (if applicable)

I, _____ the parent/ legal guardian of, _____ authorize physical therapy treatment to be administered by Promotion Physical Therapy, P.C.

Acknowledgement of Review of Notice of Privacy Practices (copy provided via email and is available in office)

I have been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

INITIALS: _____

Personal Valuables

I hereby release Promotion Physical Therapy, P.C., and its associates of any and all responsibility for loss or damage to personal property, including but not limited to clothing, money, or other valuables kept in my possession or brought in by me or anyone with me during my care.

INITIALS: _____

Contact Authorization

I hereby authorize Promotion Physical Therapy, P.C., to contact me and/or a minor under my guardianship via phone, text, or e-mail in regards to my medical care.

INITIALS: _____

Assignment of Insurance Benefits

I hereby authorize any and all insurance carriers, Medicare, and/or appropriate agencies to pay directly to Promotion Physical Therapy, P.C., benefits due me, if any, by reason of services described in the statement rendered.

INITIALS: _____

Insurance Benefits Information (***To Be Completed by Front Office staff at Initial Visit)***

Based on the information your insurance company provided to Promotion Physical Therapy, P.C., the payment amount you are responsible for is listed below.

Primary Insurance Benefits Information

☐ Co-pay of $_____ per visit

☐ Co-insurance payment of _____%. This amount is estimated to be $_____ per visit. (Please note that **this is just an estimate** and the actual dollar amount may be more or less. Therefore, you may owe more money once the claims have been filed.)

☐ Deductible of $_____, of which $_____ is still remaining. To meet your deductible, you have two payment options:

A. Pay the deductible in full on your first visit

OR

B. Make payments towards your deductible of **$_____** each visit until the deductible is met. (Please note that if you do not meet your deductible before you complete physical therapy, the **$_____ is simply an estimate** of what each visit costs. Therefore, you may owe more money once the claims have been filed.)

☐ Out of Pocket of $_____ has been met and you are covered at 100% up to plan limitations.

To be completed by Front Office Personnel		
Visits Allowed:	Hard Max or BOMN	Subject to Medical Review? Yes No

INITIALS: _____

Secondary Insurance Benefits Information

☐ Co-pay of $_____ per visit

☐ Co-insurance payment of _____%. This amount is estimated to be $_____ per visit. (Please note that **this is just an estimate** and the actual dollar amount may be more or less. Therefore, you may owe more money once the claims have been filed.)

☐ Deductible of $_____ will need to be met before payment for services will be considered by the insurance company.

To be completed by Front Office Personnel		
Visits Allowed:	Hard Max or BOMN	Subject to Medical Review? Yes No

INITIALS: _____

Medicare Benefits

The annual Medicare deductible is $240.00, of which $_____ is still remaining. Collection of $_____ per visit will apply until deductible is met.

The annual Medicare cap for Physical Therapy and SLP (combined) is $2,330.00. There is $_____ of Physical Therapy and SLP cap remaining, approximately _____ visits. The Medicare coverage plan is 80% / 20%, meaning the patient will be responsible for 20% of the Medicare allowable charges. These charges may be paid by a secondary insurance policy (if applicable) or paid by the patient after all claims have been submitted to Medicare.

INITIALS: _____

Secondary Insurance Benefits

☐ Secondary insurance **WILL** cover Medicare deductible and/or co-insurance.

☐ Secondary insurance **WILL NOT** cover as primary if Medicare benefits are exhausted.

☐ Secondary insurance **WILL** cover as primary if Medicare Benefits are exhausted with the following:

- ☐ Co-pay of $_____ per visit.
- ☐ Co-insurance payment of _____%. This amount is estimated to be $_____ per visit. (Please note that **this is just an estimate** and the actual dollar amount may be more or less. Therefore, you may owe more money once the claims have been filed.)
- ☐ Deductible of $_____ will need to be met before payment for services will be considered by the insurance company.

To be completed by Front Office Personnel		
Visits Allowed:	Hard Max or BOMN	Subject to Medical Review? Yes No

INITIALS: _____

Private Pay Information

Private Pay rate of $_____ per visit.

INITIALS: _____

Pelvic Health Supplies

A charge of $_____ per every 10 visits will be collected to cover the cost of single use supplies that may not be covered by your insurance company. Should your treatment not involve any single use supplies, any credit will be applied to your account or refunded to you upon discharge.

INITIALS:_____

Consent to Pay

If applicable, Promotion Physical Therapy, P.C. will contact your insurance company to verify your physical therapy coverage. **Please be advised that the information your insurance company provides to us is only a quote of your benefits and not a guarantee of payment. It is the policy of Promotion Physical Therapy, P.C., to file claims on your behalf with your insurance company. Your financial responsibility (co-pays, co-insurance, deductibles, etc.) is based on the benefits quoted by your insurance company before your claims are submitted. Therefore, you may owe additional money after the claims are processed by your insurance company. If insurance does not pay in a timely manner, the Guarantor must pay the remaining balance within (30) days from the time the insurance payment has ceased or from the time the insurance company notified us that they will not pay.** (Note: The guarantor of each account is ultimately responsible for payment of the account in full.)

I understand and agree that I am responsible for all of my deductible, co-pay, and/or co-insurance payment in full on each and every visit. We are required to collect payment in the amount listed below prior to the start of each treatment session.

We accept payment in the form of credit card, debit card, Care Credit, cash, or personal check. I understand all credit card payments have an automatic 3% processing fee applied to each transaction. The processing fee does not apply to any debit card, Care Credit or FSA/HSA charges.

Patient / Guardian Signature	Date	Company Representative	Date

Cancellation and No-Show Policy

Promotion Physical Therapy, P.C., strives to provide each patient with the highest quality care while accommodating your schedule. Therefore, we reserve specific time-allotments for each patient. It is critical for you to consistently attend your scheduled appointments in order to achieve the goals that you want to achieve.

We respectfully request 24-hours advanced notice of any appointment cancellation. If we do not receive advanced notice of a cancellation, our ability to meet the scheduling needs of our other patients is limited. **If you cancel without a 24-hour notice or arrive more than 15 minutes late for your scheduled appointment time, you will be charged a $35.00 Cancellation/ No-Show Fee for standard appointments and a $50.00 fee for pelvic health sessions.** *In addition, if you do not keep your appointments,* ***your treatment program will be terminated after the second NO-SHOW or third CANCELLATION*** *and your physician will be notified immediately.* We recognize legitimate reasons for missing appointments and keep accurate records of those occurrences, but we need your cooperation in contacting our office as soon as possible when you will be unable to keep your scheduled appointments.

TriWest & Worker's Compensation Patients

All cancellations and NO-SHOWS will be documented in your medical record and appropriately reported to your physician, employer, payer, adjustor (if applicable). **Be advised, every appointment for which you do not show will be reported that same day.** Thank you for your cooperation and consideration of our staff and other patients.

I have read the Cancellation and No-show Policy of Promotion Physical Therapy, P.C. I understand its contents and agree to the terms above.

Patient Signature	Date
Company Representative	Date

NOTICE OF PRIVACY PRACTICES

YOUR RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Ask us to correct your medical record • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests. Ask us to limit what we use or share • You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. • We will say "yes" unless a law requires us to share that information. Get a list of those with whom we've shared information • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Get a copy of this privacy notice • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated • You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting Www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: • Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we *never* share your information unless you give us written permission: • Marketing purposes • Sale of your information • Most sharing of psychotherapy notes. In the case of fundraising: • We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you • We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.* Run our organization • We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services • We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.* How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. Help with public health and safety issues • We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety

Do research • We can use or share your information for health research. Comply with the law • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests • We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director • We can share health information with a coroner, medical examiner, or funeral director when an individual dies. Address workers' compensation, law enforcement, and other government requests • We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services. Respond to lawsuits and legal actions • We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES:

• We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it. • We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. Changes to the Terms of This Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request or in our office. This Notice of Privacy Practices applies to the following organizations – *Promotion Physical Therapy*

David G. Muniz, Privacy Officer, 10415 State Highway 151, Ste. 101 (p) 210-647-9970, (f) 210-647-7229