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 desk 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: 15614 Huebner Road, Ste. 115, 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: 9502 Huebner Road, Bldg. 301, 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

PATIENT INFORMATION:

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

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

Address:_____ Home Phone: (_____)_____

City/State/Zip:_____ Mobile Phone:(_____)_____

Marital Status: _____ Occupation:_____

Email: _____

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 having 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? Yes No

   If so, how many visits? _____
5. Have you had this year or are you currently receiving any Home Health Services such as PT, OT, ST, Social Worker, Aide, Nurse, etc? Yes No

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

   _____
6. Have you had surgery for this condition? 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:

Secondary 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	☐	☐	HIV / AIDS
☐	☐	Bronchitis	☐	☐	Osteoarthritis
☐	☐	Bowel/Bladder Problems	☐	☐	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	☐	☐	Current have surgical implants?
☐	☐	Hepatitis	☐	☐	Currently have a pacemaker?
☐	☐	High Blood Pressure			

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 2 hours before and 2 hours after 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:**_____

For Office Use Only

Height: _____ Weight: _____ Staff Initials: _____

<u>MEDICATION LIST</u>: Additional sheets are available if needed.

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 appetitie 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 figety 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 AUTHORIZATION:

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.

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: _____

Consent to Pay (circle one) Commercial Ins. Private Pay Medicare

Promotion Physical Therapy, P.C. will contact your insurance company to verify your physical therapy coverage (if applicable). **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 for you 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.)

Based on the information your insurance company (if applicable) provided to Promotion Physical Therapy, P.C., the amount that you are responsible for is:

_____ 1. Co-pay of $_____ per visit
Initials

_____ 2. Co-insurance payment of _____%.
Initials 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.)

_____ 3. Deductible of $_____. To meet your deductible, you have two payment options:
Initials

_____ 1. Pay the deductible in full on your first visit
Initials

OR

_____ 2. You can make payments towards your deductible of **$_____**
Initials each visit until you meet your deductible. (Please note that if you do not meet your deductible before you finish physical therapy, the **$_____ is simply an estimate** of what each visit costs. Therefore, you may owe more money once the claims have been filed.)

MEDICARE BENEFITS (if applicable):

_____ 1. The annual Medicare deductible is $198.00, of which $_____ is
Initials still remaining. Your deductible will not be collected until all claims have been submitted to Medicare and secondary insurance (if applicable).

_____ 2. The annual Medicare cap for Physical Therapy is $2,080.00. There is
Initials $_____ of Physical Therapy cap remaining (approx. ____ visits). The Medicare coverage plan is an 80% / 20%. 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.

SECONDARY INSURANCE BENEFITS (if applicable):

_____ 1. Co-pay of $_____ per visit
Initials

_____ 2. Co-insurance payment of _____%.
Initials 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.)

_____ 3. Deductible of $_____ will need to be met before payment for services will be considered by
Initials the insurance company.

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 the above amount prior to the start of each treatment session. Our front office staff can accept payment from you with a credit card or check.

Acknowledgement of Review of Notice of Privacy Practices

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: _____

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, you will be charged a $35.00 Cancellation/ No-Show Fee.** *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.

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.

INITIALS: _____

TriWest & Worker's Compensation Patients

All cancellations and NO-SHOWS will be documented in your medical record and appropriately reported to your physician, employer, and adjuster. **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.

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 email in regards to my medical care.

INITIALS: _____

_____ _____

Patient/ Guardian Signature Date

_____ _____

Company Representative Signature Date