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 clinic 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 visit, 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 staff, 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, 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: ______________________________ Email: ____

Emergency Contact: ____ Phone: (______)_____________________________

Occupation: ____

REFERRING PHYSICIAN:

Name: _____________________________________ Phone: (______)_______________________

ADDITIONAL INFORMATION:

1. **Is this a work-related injury**? Yes No Date of 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:

   Attorney's Name & Phone Number: ____

4. **Have you received <u>any</u> physical therapy for <u>any</u> 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 Home Health Agency & Phone Number: _______________________________

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: ____

HEALTH INSURANCE:

Primary	Secondary
Primary Insurance: ________________________________	Secondary Insurance: ______________________________
Insurance ID#: ___________________________________	Insurance ID#: ___________________________________
Policy Holder Name: ____________________________	Policy Holder Name: ____________________________
Policy Holder DOB: _____________________________	Policy Holder DOB: _____________________________
Policy Holder SSN: _____________________________	Policy Holder SSN: _____________________________
Relationship to Patient: __________________________	Relationship to Patient: __________________________

For Office Use Only:
Intake completed by: ____ Date: ___________________________

PAST MEDICAL HISTORY:

Please check “**Yes**” or “**No**” to all the medical conditions listed below that you currently have or that you have previously had:

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

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

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

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.

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

Name:____________________________ **Signature:**____________________________ **Date:**_________

For Office Use Only

Height: ________________ Weight: ________________ Staff Initials: _______

Patient: ______________________________

Please list all medications, vitamins and supplements that you are currently taking:

MEDICATION LIST			
Name of Medication, Vitamin or Supplement	**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)			

An additional sheet can be provided if your list exceeds what is allowed on this page.

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, W/C 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

Commercial Ins. Private Pay Medicare (circle one)

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:

_______ Initials 1. Co-pay of $__________ per visit

_______ Initials 2. 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.)

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

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

OR

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

MEDICARE (if applicable):

______ Initials 1. The annual Medicare deductible is $185.00, of which $__________ is still remaining. Your deductible will not be collected until all claims have been submitted to Medicare and secondary insurance (if applicable).

______ Initials 2. The annual Medicare cap for Physical Therapy is $2,040.00 There is $________ 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 (if applicable):

_______ Initials 1. Co-pay of $__________ per visit

_______ Initials 2. 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.)

_______ Initials 3. Deductible of $__________ will need to be met before payment for services will be considered by 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 $25.00 Cancellation Fee.** In addition, if you do not keep your appointments, **your treatment program will be terminated after the second consecutive NO-SHOW or third consecutive 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: __________

Medicare Patients Only:

Due to recent changes in our national healthcare system, any patient who has Medicare as their health insurance MUST notify the treating physical therapist on the last day he or she will be attending physical therapy. Therefore, on your last day of physical therapy, you must inform your physical therapist so they can report the necessary codes Medicare demands. This may seem insignificant, but it carries serious consequences. If you do not notify your physical therapist on your last day then Medicare will actually deny some of your medical benefits!

We understand that sometimes patients feel great in between their physical therapy treatments and feel they do not need to return for another follow-up visit. However, you must return for one final treatment so that we can report the necessary codes. This is not our policy, but a new federal requirement from Medicare. Medicare will deny some of your medical benefits if you do not comply with this regulation!

By signing below, you acknowledge that you understand this regulation and agree to either notify your physical therapist on your last day of treatment, or return for one last visit so we are in compliance with federal regulations and you are not denied any of your medical benefits.

INITIALS: __________

______________________________ ______________________

Patient/ Guardian Signature Date

______________________________ ______________________

Company Representative Signature Date