Ried
Physical Therapy

PATIENT INFORMATION

Date: ___/___/___

Name: _____ _____ _____ **Soc Sec #:** ___-___-____
Last Name First Name Initial

Address: _____ **City/State/Zip:** _____

Home Phone: ___-___-____ **Work Phone:** ___-___-____ **Cell Phone:** ___-___-____

E-Mail Address: _____ **Cell Phone Provider:** _____

Would you like to receive appointment reminders by: ☐ **Email** ☐ **Text Message**

Sex: Pick One **Birthdate:** ___/___/____ **Age:** ____ ☐**Single** ☐**Married** ☐**Widowed** ☐**Separated** ☐**Divorced**

In case of an emergency, please notify: _____ ***Phone:*** ___-___-____

Patient Employer: _____ **Occupation:** _____

Employer Address: _____ **City/State/Zip:** _____

Tricare patients:

Sponsor Name: _____ **Sponsor Birthdate:** ___/___/____

Sponsor Employer: _____ **Sponsor Soc Sec #:** ___-___-____

Referring Physician: _____ Primary Physician: _____

Approximate Injury Date: _____

Who may we thank for this referral? _____

Assignment, Release and Consent:

I, the undersigned, certify that I (or my dependent) has insurance coverage with _____ and assign directly to **Ried Physical Therapy** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Ried Physical Therapy** to release all information necessary and use this signature to secure the payment of benefits. I further certify that the above patient information and history is accurate and complete. I understand and agree to abide by the cancelation policy set forth by **Ried Physical Therapy** as posted. I authorize **Ried Physical Therapy** to use any of the means of contact listed above to communicate with me, including but not limited to phone calls, voicemail, email, and text message unless otherwise indicated. I hereby authorize and give my consent for treatment of the condition for which my physician referred me. Outcomes cannot be guaranteed, however, if you feel that you did not get the best service/ care possible, let us know and we will refund your payment for that day.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (if applicable) Date

Patient Name: _____

Pain level 0-10 (0 = no pain, 10 = excruciating pain, call 911):

Current: Current Pain (0-10)

Worst: Worst Pain (0-10)

Best: Best Pain (0-10)

Location of pain on body: _____

When and how did your pain begin? _____

_____

Pain relieved/better with: _____ Pain worse with: _____

Have you received physical, occupational, speech, chiropractic therapy or home health services in the past year? ☐ **Yes** ☐ **No**

If for this injury, what was the result? _____

Are you currently receiving any Home Health services? Select One

Presently Working: Select One Hand Dominance: Select One

Current job status/duties: ☐ Normal ☐ Modified duty ☐ Off work ☐ Unemployed ☐ Retired

Medical History – Please indicate if you have had any of the following and dates if applicable:

Heart Problems	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Allergies	☐ Y	☐ N
Lung Problems	☐ Y	☐ N	Back/Neck Problems	☐ Y	☐ N
Asthma	☐ Y	☐ N	Shortness of Breath	☐ Y	☐ N
Dizziness	☐ Y	☐ N	Chest Pain	☐ Y	☐ N
Stroke	☐ Y	☐ N	Traumatic Head Injury	☐ Y	☐ N
Blood in Urine	☐ Y	☐ N	Hernia	☐ Y	☐ N
Cancer	☐ Y	☐ N	Arthritis	☐ Y	☐ N
Seizures	☐ Y	☐ N	Osteoporosis	☐ Y	☐ N
Pace Maker	☐ Y	☐ N	Other: _____		

Height: _____ Weight: _____ Smoker: ☐ Y ☐ N

Current Medications: _____

_____

Brief medical/surgical history (including date, if applicable): _____

_____

_____

Texas Board of Physical Therapy Examiners

333 Guadalupe, Ste 2-510 ***512/305-6900 • 512/305-6951 fax***
Austin, Texas 78701-3942 ***http://www.ptot.texas.gov***

Physical Therapy Treatment without Referral Disclosure

Please read carefully and acknowledge below:

I understand that physical therapy treatment without a referral will be based on the physical therapist's examination and evaluation of my current condition which may result in identification of movement and mobility dysfunction.

I understand that the physical therapist will not diagnose an illness or disease, and that physical therapy is not a substitute for a medical diagnosis.

I understand that if a medical diagnosis has already been established by a qualified healthcare practitioner, the physical therapist will take it into consideration during the evaluation process.

I understand that the physical therapy plan of care developed by the physical therapist may not be based on radiological imaging.

I understand that if images have previously been obtained, the physical therapist may use the information as part of the evaluation process.

I understand that if the physical therapist identifies a need for radiological imaging, the physical therapist may recommend that radiological imaging be obtained.

I understand that my health insurance may not cover physical therapy services if provided without a referral from a qualified healthcare practitioner.

I acknowledge that I have received the above disclosure.

Patient Name (print): _____

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Print Name and Relationship to Patient

Approved by the Texas Board of Physical Therapy Examiners – 10/11/2019

24Hr Cancellation/No Show Policy

We have a One-on-One hands-on therapy approach that helps our patients get back to doing what they love to do. In order to allow us to offer One-on-One therapy, we have a 24-hour cancellation policy. A charge of $40 may be added if someone cancels their appointment without a 24-hour notice.

After the 1st cancelled appointment without a 24-hour notice, all following cancelled appointments may result in being charged the full amount of a physical therapy session.

Appointments that are No Showed will follow the same guidelines as cancelled appointments but are subject to being discharged after the 3rd No Show at office's discretion.

We require patients to keep a card on file and you agree for the card to be charged for outstanding balances or Cancellation/No Show fees. Thank you for your understanding.

Sign: _____ Date: _____