ALLIED Therapies
OF TEXAS
Physical Therapy • Occupational Therapy • Speech Therapy

1521 East US 190 * Copperas Cove, TX 76522
Web site: www.AlliedTherapiesTX.com Email: office@alliedtherapiestx.com
Ph 254-238-7836 Fx 833-238-8515

Patient Information

First Name:_____ Last Name:_____

Gender: M F Date of Birth:_____ SS# _____

Address:_____ Apt./PO Box:_____

City:_____ State:_____ Zip:_____

E-mail address:_____

How did you hear about us? Please circle one: Internet Doctor Insurance Friend
Who?:_____Other:_____

Phone Numbers

Home Phone:_____Work Phone:_____

Cell Phone:_____ Preferred Appt Reminder (circle one): Text Email

Cell Phone provider: _____ (Required for text reminders)

Emergency Contact

First Name:_____ Last Name:_____

Phone Number:_____ Relationship:_____

For Tricare Patients Only: Is this person also your sponsor? YES NO

If yes, what is their SS#? _____

If yes, what is their DOB: _____

Is this person authorized to take the patient from the clinic?(circle one): YES NO

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Primary Insurance:_____ ID #:_____

Group #:_____ Claim #:_____

Deductible:_____ Max Annual Benefit:_____

Copay:_____ Coinsurance:_____

Subscriber Full Name:_____ Subscriber DOB:_____

Subscriber Relation to Patient:_____

Secondary Insurance:_____ ID #:_____

Group #:_____ Claim #:_____

Deductible:_____ Max Annual Benefit:_____

Copay:_____ Coinsurance:_____

Subscriber Full Name:_____ Subscriber DOB:_____

Subscriber Relation to Patient:_____

Tertiary Insurance:_____ ID #:_____

Group #:_____ Claim #:_____

Deductible:_____ Max Annual Benefit:_____

Copay:_____ Coinsurance:_____

Subscriber Full Name:_____SubscriberDOB:_____

Subscriber Relation to Patient:_____

EmployerCompany Name:_____

Address:_____ Suite/Office #:_____

City:_____ State:_____ Zip:_____

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Primary Care Physician (full name if known):_____

Clinic:_____

Clinic Address (if known):_____

Clinic Phone (if known):_____

Problem

Problem Description:_____

Date of Onset:_____

Current Medications:_____

Known Allergies:_____

1st Surgery – Related to what we are treating

Type of Surgery:_____

Date of Surgery:_____

Current Doctor Restrictions (if any): _____

2nd Surgery - Related to what we are treating

Type of Surgery:_____

Date of Surgery:_____

Motor Vehicle Accident Injuries

If you are receiving care for injuries from a Motor Vehicle Accident, what state did the accident occur in? _____

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Patient or Guardian Agreement:

• I authorize release of information requested by my insurance plan for payment.

• I understand that I am responsible for any balance due not covered by my insurance, including co-pays, coinsurances, and deductibles

• I understand that any co-pays required by my insurance company are due at the start of my treatment session.

• I agree to comply with the terms and conditions as outlined in the Patient Registration form.

• I understand that I must notify Allied of any changes in insurance and/ or primary care provider immediately.

Signature of Patient/Guardian:_____
Date:_____

Emergency Medical Treatment Release

I, _____, do hereby give my consent to the Directors of Allied Therapies of Texas to administer medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of emergency in the event my consent can not be obtained.

Signature:_____
Date:_____

Notice of Privacy Practices, Privacy Sheet, Patient Rights and Responsibilities, Attendance Policy, and Clinic Rules (Laminated Pages if in clinic or attached if via email)

I have read the laminated document provided with this patient intake packet and understand it. I understand that I have the right to ask for a non-laminated copy of the document (or sections of the document) to take home, or have a copy emailed to me. I know that I can also find this document on the clinic website, www.alliedtherapiestx.com.

I have read, understand, and agree to the Notice of Privacy Practices, Privacy Sheet For Client, Patient Rights and Responsibilities, Attendance Policy, and the Clinic Rules. I consent to the use and disclosure of my healthcare information for purposes of treatment, payment, and healthcare options.

_____ _____

Signature Date

If you are signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____ _____

Signature Date

Source of Authority/Relationship:_____

Evaluation Explanation

Thank you for the opportunity to perform your evaluation. It is our goal and mission to serve the individuals in our area, help them be more independent, and to improve their quality of life.

After the evaluation is performed, your therapist will use the information collected to determine what intervention is appropriate. If therapy is recommended, we will send a request for treatment to the physician to obtain a prescription for treatment. It may take several weeks for your physician to return the prescription for treatment and your insurance provider to authorize therapy treatment. We encourage you to follow up with your physician and insurance provider to ensure communication between parties and timely initiation of therapy treatment. As soon as we receive the prescription for treatment and authorization, we will contact you to begin your therapy treatment. Therapy treatment often is recommended 2 to 3 times per week for 30 to 60 minutes each session. The exact amount will be determined by the therapist. Please be sure that you can commit to this amount of time for your therapy. As explained in our attendance policy, consistent attendance and participation in therapy is vital to patient progress.

Your therapist may discuss the results with you if there is time. If therapy is recommended, the therapist may even discuss possible treatment days and times with you. If you have any questions or concerns about the evaluation or treatment scheduling, please do not hesitate to bring them to the attention of your therapist.

If at any time you have any questions about how this process works or a concern about therapy, please ask. It is our goal to meet and exceed your expectations for therapy.

Thank you for choosing us,

Allied Therapies of Texas

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Privacy Signature Sheet For Patients

Patient Name: _____ Phone #: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices.

When you sign this consent document, you signify that you agree that we can & will use & disclose your health information to treat you, to obtain payment for our services & to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in the Notice of Privacy Practices, we are not obligated to agree to these restrictions. If we do agree, the restrictions are binding on us.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Allied Therapies of Texas.

Signature Date

In signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Signature Date

Source of Authority/Relationship: _____

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Attendance Policy

At Allied Therapies of Texas, we believe that consistent patientattendance and participation in therapy is absolutely necessary to achieveresults. We wish to ensure the highest possible level of clinical success;therefore, we adhere to the following attendance policy:

Appointments must be cancelled a minimum of 24 hours in advance of yourscheduled appointment start time. Canceled appointments can often berescheduled if planned in advance. We encourage the rescheduling ofmissed visits in order to keep therapy results consistent. If attendance dropsbelow 50% within a 30 day period for any reason, you will be notified and you
may lose your regularly scheduled appointment time. Your physician will alsobe notified of any frequent absences or termination of therapy.

An absence is considered a **No Show** anytime Allied does not receivenotice of a cancellation **PRIOR** to the appointment start time. If we do nothear from you, or hear from you after the appointment start time has passed,the visit will be considered **No Show** status. The regular appointment time islost after 3 No Show appointments, without exception.Cancellations without 24 hour notice and No Show appointments will besubject to a fee of $25 per incident, due at the time of the next visit.

As a courtesy, please give Allied as much advance notice as possible in theevent of a cancellation. Often, those openings can be utilized to scheduletherapy for other patients. Cancellations without adequate notice are amissed opportunity for both the patient to receive benefit from services andfor the therapist to provide services to other individuals who may be in need.

Illness

We understand that cancellations due to illness are unavoidable. We do notallow individuals who have shown one or more of the following symptoms ofcontagious disease within the last 24 hours to receive treatment:

Fever > 100 degrees
Open/Draining Lesion
Vomiting/Nausea
Lice
Chicken Pox
Measles
Productive Cough
Conjunctivitis/Pink Eye
Hand, Foot, and Mouth Disease
Strep Throat
Diarrhea
Any Other Contagious Disease Not Listed

This will aid in the protection of the health of staff, other patients, and familymembers. Cancellations of less than 24 hours' notice due to contagiousdisease will not be subject to penalty; however, please be aware that Allied Therapies may request a doctor's note before resuming therapy.

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Holidays

Allied Therapies of Texas is officially closed on the following holidays:

Thanksgiving
Christmas
New Year's Day
Independence Day

For all other holidays, please check directly with your treating therapist to determine availability.

Inclement Weather

In instances of inclement weather, we follow the closings and delay schedule of the Killeen school district. If the clinic is closed due to inclementweather, your treating therapist will contact you to confirm closing andreschedule your appointment.Client safety is extremely important to us.
Please contact us if hazardous conditions prevent safe transportation totherapy.

By signing this document, I certify that I have read and agree to abide by the Attendance Policy.

_____

Patient/Parent/Guardian Date

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Review of Systems

Name:_____ Today's Date:_____

If you have pain, how do you describe it? Achy Superficial Dull Burning Numbing Pins/Needles Throbbing Pulsing Pounding Beating Deep Sharp Boring Stabbing Other:_____
Pain Frequency: (Circle One) Constant Intermittent (comes and goes)
When is the pain worse: (Circle One) Waking up AM Midday PM Middle of the night?

Are your symptoms?

Poorly localized & widespread?	Y	N	Changed with eating/diet?	Y	N
Unrelieved with medication?	Y	N	Relieved by aspirin?	Y	N
Progressive (getting worse over time)?	Y	N	Deep and dull?	Y	N

Constant or unwavering regardless what you do? Y N
Unrelieved by rest or change in position? Y N
Constant or unwavering regardless what you do? Y N

***Do you have*:**

1. cancer or a family history of cancer? Y N
2. unexpected weight loss? Y N
3. changes in your bowel or bladder function? Y N
4. pain that awakens you at night? Y N
   if yes, is it relieved by a position change? Y N
5. abdominal pain? Y N
6. angina, chest pain, palpitations, fluttering, heart disease? Y N
7. dizziness, lightheadedness, fainting, blackouts, vertigo Y N
8. a fever, chills, nausea, vomiting, constipation, or diarrhea? Y N
9. An ulcer, GERD/heartburn? Y N
10. shortness of breath, asthma, or pain with breathing? Y N
11. hoarseness? Y N
12. chronic bronchitis? Y N
13. emphysema/COPD? Y N
14. pneumonia? Y N
15. night sweats or unexplained excessive perspiration? Y N
16. a change in symptoms with your menstrual cycle? Y N n/a
17. a history of endometriosis? Y N n/a
18. difficulty with swallowing, speaking, or loss of appetite? Y N
19. a history of taking oral corticosteroids (ie prednisone)? Y N
20. an autoimmune disorder (ie lupus, rheumatoid arthritis, scleroderma, ulcerative colitis Grave's/Hashimoto's, Crohn's, Multiple Sclerosis, Polymyositis, enteritis)? Y N

21. blood in your stool, urine, vomit, or mucus? Y N
22. dribbling or leaking urine? Y N
23. prostrate problems? Y N n/a
24. uninary tract infection? Y N
25. a skin rash, swelling, lumps, or thickening of the skin? Y N
26. Contagious Disease, MRSA, infectious disease (ie hepatitis/HIV)? Y N
27. pelvic inflammatory disease? Y N
28. epilepsy or seizures? Y N
29. fibromyalgia or myofascial pain? Y N
30. Polio/postpolio? Y N

31. Rheumatic or Scarlet fever?	Y	N	36. Parkinson's Disease	Y	N
32. recent changes in vision/hearing?	Y	N	37. Hypoglycemia?	Y	N
33. varicose veins?	Y	N	38. eating disorder?	Y	N
34. peripheral Vascular Disease?	Y	N	39. hemophilia?	Y	N
35. Guillain-Barre Syndrome?	Y	N	40. high cholesterol?	Y	N
41. history of strokes/TIAs?	Y	N	46. Ankle Swelling?	Y	N
42. Osteoarthritis?	Y	N	47. Osteoporosis?	Y	N
43. Tuberculosis?	Y	N	48. Kidney Disease?	Y	N
44. Dementia/Alzheimers?	Y	N	49. Diabetes?	Y	N
45. High Blood Pressure	Y	N	50. Low Blood Pressure?	Y	N

Are you Pregnant? Y N n/a
Have you recently taken Lipitor/Zocor? Y N Muscle pain or weakness? Y N
Have you had a recent infection? Y N Did you take an antibiotic? Y N
Have you had recent lab work such as blood work or uninalysis? Y N
Have you had chemo, radiation, biotherapy, or brachytherapy? Y N
Do you have a pacemaker, organ transplant, joint replacement, breast implant, other implant? Y N

Do you have a History of Smoking? Y N If Yes, now many packs/day? _____
How many years have you smoked? _____

Do you have a skin sensitivity? Latex _____ Adhesive _____ Temperature _____

Do you have a fear of falling? Y N Have you fallen? Y N How many times?____
(per CMS: 2 or more falls in past yr or 1 fall resulting in an injury = fall risk screen)
Are you depressed? Y N Are you afraid someone wants to hurt you? Y N