**PHYSICAL THERAPY**
**Sports & Wellness**

1602 Aquarena Springs Dr. Suite 101, San Marcos, TX 78666 512-667-9479
StrivePhysicalTherapyTX@gmail.com www.StrivePhysicalTherapyTX.com

# PATIENT INFORMATION

Name: ______________________________________________

Date of Birth: ______________________ Sex: Male Female

SSN: ______________________ Home Phone: ______________________

Address: ______________________ Cell Phone: ______________________

City: ______________________ Consent to Text: Yes No

State: ______________________ Email: ______________________

Zip Code: ______________________ Marital Status: ______________________

For updates/reminders which is the best to contact you by: Phone Email Text

Primary Care Physician: ______________________________________

# CONSENT TO TREATMENT

I understand, consent and agree that I will be seen, evaluated and treated by a licensed physical therapist. I further understand that I may also be seen upon occasion by a fully trained and qualified associate under the guidance and direction of the licensed physical therapist.

Printed Name: ______________________________________________

Signature: ______________________________ Date: ______________

# PAST MEDICAL HISTORY

**Please fill out completely and accurately. This becomes a part of your permanent record and will help us to make recommendations regarding your care.**

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Patient Name: ______________________________ Date of Birth: ______________

Referring Physician: ______________________________________

**Do you currently or have you ever had any of the following:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Arthritis | ☐ | ☐ | HIV/AIDS | ☐ | ☐ |
| Asthma/Chronic Bronchitis | ☐ | ☐ | Kidney Disease | ☐ | ☐ |
| Bowl/Bladder Problems | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Cancer | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | Stroke | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Epilepsy/Seizures | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Heart Disease/Attack | ☐ | ☐ | Alcoholism | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Drug Abuse | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Tobacco Use | ☐ | ☐ |

**Do you have any current or past health problems that are not listed above?**

______________________________________________________________

______________________________________________________________

**Please list all surgeries and the approximate date of the operation:** ______________

______________________________________________________________

**Please list all medications you are currently taking:** ______________________

______________________________________________________________

**List any known allergies:** ______________________________________

**Are you currently pregnant or nursing:** **Yes** **No** ______________________

**Please list the condition that you have been referred for:** ____________________

**Date of Injury:** ____________________________________________

## ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have reviewed a copy of Strive Physical Therapy Sports & Wellness, PLLC's Notice of Privacy Practices with an effective date of April 1, 2017. I understand I can ask for a personal copy at any time.

Name of Patient ______________________________

Signature of Patient______________________________

Date: ________________

## MISSED APPOINTMENT FEE NOTICE

In order to provide quality medical care, it is important that we hear from you *prior* to your appointment if you are unable to come in. Continued missed appointments may result in dismissal of care from our practice. We would appreciate if you could please give us a call 24 hours in advance if you need to reschedule your appointment in order to prevent paying a $20.00 missed appointment fee.

Thank you,

Strive Physical Therapy Sports & Wellness

Patient Signature: ______________________________Date: ______________

## AUTHORIZATION TO TREAT A MINOR

I hereby authorize evaluation and treatment by Strive Physical Therapy Sports & Wellness physical therapists and/or physical therapist assistants/volunteers for my son/daughter, ______________________________, for the ________________ injury (or chronic condition) under the following conditions:

☐ In the absence of a parent/legal guardian.

☐ Accompanied by: ______________________________

I furthermore authorize my insurance benefits to be paid directly to the above physical therapist and I also authorize the release of pertinent medical information to insurance carriers.

Signature of Parent or Legal Guardian: ______________________________

# FINANCIAL POLICY

Thank you for choosing Strive Physical Therapy Sports & Wellness as your physical therapy provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you read, and sign prior to treatment.

**ALL COPAYMENTS ARE DUE AT TIME OF SERVICE**
**WE ACCEPT: Cash, Check, Master Card, Visa, American Express, and Discover**

**Regarding Insurance:**
In order to accommodate the needs and request of our patients, we have enrolled in numerous managed care insurance programs. Our billing department will file your insurance claim as a courtesy to you. While we are pleased to be able to provide this service to you, but it is extremely difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed. Providing quality medical care for our patients is our primary concern. It is recommended that the patient also contact their insurance company prior to their first appointment to inquire about their medical benefits. It is also the patient's responsibility to contact their insurance company to inquire why a claim has not been paid and why any additional payment other than the usually co-payment is due. (This may include but is not limited to: deductibles, coinsurance, and treatment that are not covered under your plans provisions.) Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

**Debt Collections**
We may disclose your contact, insurance and medical information to a collection agency representative to assist in debt collection. If your account is sent to collections, you or your guarantor, agree to reimburse us for fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

**Minor Patients**
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.
**Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy, I understand and agree to this Financial Policy.**

Printed Name: ______________________________

Signature: ______________________________ Date: ______________

## RESPONSIBLE PARTY/INSURANCE CARDHOLDER
## (If different than above patient information)

Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone Number: ______________________ Cell Phone: ______________________
Date of Birth: ______________________ Sex: __________ SSN: ______________________
Employer: ______________________________ Marital Status: ______________