INSURANCE VERIFICATION FORM

LONGVIEW FAMILY PHYSICAL THERAPY

Patient Name:
Primary Insurance
Insurance Name:
Deductible:
Out of Pocket:
Authorization Required? Y / N
Visit Limit:

Estimated Cost Per Visit:

I acknowledge that my benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Longview Family Physical Therapy (LFPT) if I do not understand my benefits, have questions regarding payment, or if I am unable to provide payment for my services prior to receiving treatment. I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that LFPT has permission to collect any remaining balance using the payment method on file.

Patient Signature (or guardian if under 18): _____

Date: _____

CANCELATION POLICY

- 24-hour notice required for any cancelations or reschedules
  - Instances of same-day cancelation may incur a $30 cancelation fee.
- Longview Family Physical Therapy reserves the right to remove any future appointments from our schedule if any no-call, no-show incidents occur.
- 2 or more no-shows OR same day cancelations may result in discharge.

CANCELATION POLICY ACKNOWLEDGEMENT: _____
(Initials)

LONGVIEW FAMILY PHYSICAL THERAPY

Medical History Screening Form

General Information

Full Name: _____ D.O.B _____ Gender: _____ Height: _____

Home Address: _____ Weight: _____

Primary Phone Number: _____ Email: _____

Social Security Number: _____ Referring Doctor_____

Medical History

Hard of Hearing	Yes ____	No ____	Pacemaker	Yes ____	No ____
Diabetes	Yes ____	No ____	Depression	Yes ____	No ____
Hypertension	Yes ____	No ____	Dementia	Yes ____	No ____
Hypotension	Yes ____	No ____	COPD	Yes ____	No ____
Heart Attack	Yes ____	No ____	Asthma	Yes ____	No ____
Heart Disease	Yes ____	No ____	Clotting Disorders	Yes ____	No ____
Smoker	Yes ____	No ____	Pregnant	Yes ____	No ____
Dizziness/Vertigo	Yes ____	No ____			
Shortness of Breath	Yes ____	No ____			
Cancer/Tumors	Yes ____	No ____			
Radiation/Chemo	Yes ____	No ____			
Osteoporosis	Yes ____	No ____			
Osteoarthritis	Yes ____	No ____			
Rheumatoid Disease	Yes ____	No ____			
Stroke	Yes ____	No ____			
Parkinson's Disease	Yes ____	No ____			
Multiple Sclerosis	Yes ____	No ____			
Brain Injury	Yes ____	No ____			
Spinal Cord Injury	Yes ____	No ____			

OTHER: _____

_____

_____

Fractures: DATE _____ AREA _____

Joint Replacement: DATE_____ AREA _____

covid-19: DATE _____

Recent changes in: ☐ Bowel ☐ Bladder ☐ Night Sweats ☐ Unexplained weight loss

Allergies: _____

Date of Injury/Surgery: _____

Medications: _____

_____

_____

_____

_____

Recent Falls? Yes ____ No ____

If yes, how many falls per month: _____

Reasons/Goals for coming to therapy: _____

Patient Signature: _____ DATE: _____

(guardian's signature if patient is under 18 years old)

LONGVIEW FAMILY PHYSICAL THERAPY

109 W Hoyt Drive
Longview, TX 75601

INFORMED CONSENT PAGE

Consent to Treatment

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist. I understand services are provided to individuals of all ages, gender, color, ethnicity, creed, national origin, or disability.

2. All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Longview Family Physical Therapy, LLC does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

3. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

4. I authorize the release of my medical information to appropriate involved third parties (referring physicians, DME vendors, attorney, school's athletic trainer, etc).

5. I authorize the facility to save my credit card and/or other payment method within the billing system for ease of collection on future balances.

Communication:

I consent to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the contact information provided, including via phone, text, and email. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service.

Notice of Privacy Practices

By signing this form, I acknowledge that Longview Family Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Longview Family Physical Therapy representatives.

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form, and understand the risks involved in physical therapy. I agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

Patient Printed Name: _____ Date_____

Signature: _____

(guardian's signature if patient is under 18 years old)