WELCOME TO HUMPAL PHYSICAL THERAPY & SPORTS MEDICINE

For office use only

Date: ____________________

Location: __________________

Therapist: __________________

PATIENT INFORMATION:

NAME: ______________________________ ______________________________ _______ ________________
Last First MI Maiden

DOB: ______/______/______ **AGE**: _______ **GENDER**: ☐ F ☐ M **SS#**: _________/_______/__________

MAILING ADDRESS: ____________________________________ ___________________ ______ ___________
Street City State Zip

HOME #: _____________________________ **WORK #**: ______________________________**EXT.**__________

CELL #: ____________________________ **E-MAIL**: ____

*****If patient is a MINOR, list parent/guardian cell/home/work #s and email information above*****

RESPONSIBLE PARTY (If different from above): ☐ **Self** ☐ **Parent/ Guardian** ☐ **Other** _____________

Name: ___________________________________ Address: _____________________________________

Home Phone: ___________________Cell Phone: __________________ Wk Phone: ________________

EMPLOYMENT STATUS: ☐ **Employed** ☐ **Student** ☐ **Retired** ☐ **Other** ___________

Employer: ____ Job Title: _____________________________

Work Address:_______________________________________Work Phone:__________________________

MARITAL STATUS: ☐ Married ☐ Single ☐ Other

Spouse's Name: ____ D.O.B.: ______/______/______

Spouse's Employer: ____________________________________ Phone #: ________________________

EMERGENCY CONTACT: ____

Phone #: _______________________________ Relationship: __________________________________

Who is your Referring Physician? ____

Who is your Family Physician? ____

Have you ever had Physical Therapy for this same or similar condition? ☐ Yes ☐ No

If yes, when, where, and how long were you treated? ____

INSURANCE INFORMATION:

Primary Insurance: ______________________________ Subscriber Name: ______________________________

DOB: _______________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _______________

Secondary Insurance: ______________________________ Subscriber Name: ______________________________

DOB: _______________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _______________

IF YOU HAVE <u>MEDICARE, MEDICARE REPLACEMENT, MEDICAID, OR STATE FUNDED:</u>

Have you **EVER** received any kind of:

Home Health? ☐ Yes ☐ No If yes, When, Where, Phone #? ______________________________

Provider Care? ☐ Yes ☐ No If yes, When, Where, Phone #? ______________________________

Physical Therapy? ☐ Yes ☐ No If yes, When, Where, Phone #? ______________________________

IS YOUR CONDITION FROM AN <u>AUTO ACCIDENT</u>? ☐ Yes ☐ No

If yes, please provide the **accident report** and **Date of Injury**: ______/______/______

Name of Auto Insurance: ____

Name of other party Insurance (if any): ____

DO YOU HAVE AN <u>ATTORNEY REPRESENTING</u> YOU? ☐ Yes ☐ No

If yes, Name of Attorney: ______________________________ Phone #: ______________________

IS YOUR CONDITION FROM A <u>WORK-RELATED INJURY</u>? ☐ Yes ☐ No

If yes, provide us with a Date of Injury ___ /___ /___ and an <u>Accident Report</u> on your *next* visit.

Please Describe how you were injured:____

******FRONT OFFICE ALERT******

IF PATIENT'S CONDITION IS WORK RELATED AND HAS ATTORNEY REPRESTENTION AND THE ATTORNEY INDICATES ATTORNEY WILL BE PRIMARY OR LOP ONLY FOLLOW THE INSTRUCTIONS BELOW:

1. **VERIFY WORK COMP INFORMATION**
2. **SUBMIT FOR AUTHORIZATION**
3. **EMAIL SCOTT AND CC NORMA AND DOMINIQUE WITH THE DETAILS OF THE ACCOUNT <u>BEFORE</u> SENDING THE BILLING CHART TO DATA ENTRY.**

WOMEN ONLY: IS THERE ANY POSSIBILITY YOU MAYBE PREGNANT? ☐ Yes ☐ No

Humpal Physical Therapy & Sports Medicine

PATIENT CONSENT FORM / MEDICAL RECORDS RELEASE

Regarding the Use and Disclosure of Health Information required by Federal Law

I understand that some of my health information may be used and/or disclosed by **Humpal Physical Therapy** to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures; I should refer to your privacy notice entitled "Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time, your privacy practices may need to change in accordance with the law and that if I wish to obtain a copy of the notice as revised, I can call your office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this content in writing, but only to the extent that our practice has not taken action in reliance thereon.

I understand that for my protection, any request to amend my health information or to access my medical records must be made in writing.

I understand that I may come into contact with other patients while treated in **Humpal Physical Therapy**. I agree to not disclose any healthcare or identifiable information about any patients including their name, the reason they are being treated at **Humpal Physical Therapy**, or when they are scheduled.

I give consent to release my medical records and/or requested from **Humpal Physical Therapy** and allow the following to obtain copies. List family, friends, physicians, companies, etc. that may obtain your medical records.

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Signature: ____ Date: ______________________

CONSENT TO TREAT A MINOR

Minor Name: ____

I, the undersigned, attest that I am the custodial parent of legal guardian of the above referenced minor ("the minor"), and hereby authorize **Humpal Physical Therapy** to administer treatment, as it so deems necessary. I hereby authorize any treatment deemed appropriate by the therapists.

Signature: ____ Date: ______________________

Parent/Guardian Name: ____

HUMPAL PHYSICAL THERAPY

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

(“Agreement”)

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities (“payers”), which may elect, or be obligated to pay benefits to me for any medical condition, accidents, injuries or illnesses past or future (“condition”), to pay directly to, and exclusively in the name of, **Humpal Physical Therapy, P.C.** (HPT or “office”) such sums as may be owing **Humpal Physical Therapy, P.C.** for charges incurred by me, including, but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office (“charges”). I further grant a contractual lien to **Humpal Physical Therapy, P.C.** with respect to my charges, applicable to all payers, however I understand that nothing in this Agreement shall be construed as an election by **Humpal Physical Therapy, P.C.** to claim protection under any statutory lien law. For the purposes of this Agreement, “benefits” shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker’s compensation benefits, medical payment benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whatever such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay **Humpal Physical Therapy, P.C.**, I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to **Humpal Physical Therapy, P.C.**, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office’s name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of the office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its’ request.

I hereby authorize and direct **Humpal Physical Therapy, P.C.** to file my claims with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g., liability, medpay, attorneys, etc.), I hereby authorize and direct **Humpal Physical Therapy, P.C.** to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment.

I do agree to not hold **Humpal Physical Therapy, P.C.** and Scott A. Humpal responsible or liable for any injuries that I might sustain on and/or off the Humpal Physical Therapy facility premises. I do understand that there are risks of injury present both within the Humpal Physical Therapy facility, as well as with the treatment program itself. I agree to hold Humpal Physical Therapy and Scott A. Humpal devoid of any liability from either unintentional or intentional acts and agree to not file any claims against Humpal Physical Therapy, P.C., Scott A. Humpal or employees of Humpal Physical Therapy with respect to injuries sustained at Humpal Physical Therapy facilities and property.

I hereby direct all payers to release to **Humpal Physical Therapy, P.C.** any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **Humpal Physical Therapy, P.C.** to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize **Humpal Physical Therapy, P.C.** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due **Humpal Physical Therapy, P.C.** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Humpal Physical Therapy, P.C.** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **Humpal Physical Therapy, P.C.** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **Humpal Physical Therapy, P.C.** and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Signature: ______________________________ Date: ____/____/____

Patient Name (please print): ______________________________

Name of Custodial Parent or Legal Guardian (please print): ______________________________

Parent/Guardian' Signature: ______________________________ Date: ____/____/____

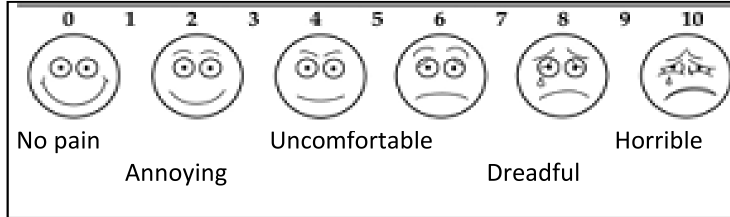
PATIENT MEDICAL HISTORY

Date: _____________

Name: ____ DOB: ________________ Age: ___________

Height: _______ Weight: _______ Next Doctor Appointment: __________ Date of Surgery: __________

Pain (Please Circle):



How many falls have you had in the last year? __________

How would you rate your current health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been treated for physical therapy for the same condition? ☐ Yes ☐ No

If yes, where? ________________________________ When?________________

Past Medical History:

	Yes	No	Date of Onset
Diabetes			
Hypertension			
High Cholesterol			
Osteoarthritis			
Rheumatoid Arthritis			
Blood Clots			
Seizures			
Cancer Type:			
Pacemaker			

	Yes	No	Date of Onset
Fibromyalgia			
Neuropathy			
COPD/ Emphysema / Asthma			
Kidney Failure			
Anxiety			
Depression			
Dementia			
Hepatitis A / B / C			
Stroke			

Past Surgical History:

	Yes	No	Date
Fusion ❑ Cervical ❑ Lumbar			
Hip Replacement ❑ L ❑ R			
Arthroscopy to _______			

	Yes	No	Date
Bone/Nerve Stimulator			
Knee Replacement ❑ L ❑ R			
Laminectomy			

Other Conditions or Surgeries (and date):

Attached Copy of Medications: ☐

List of Medications: Current Meds including prescriptions, over the counters, herbals, and vitamins/dietary (nutritional) supplements: (Name, Dosage, Frequency, and Route of Admin. (ex, oral, sublingual, injection)

Medication: ____

Medication: ____

Medication: ____

Medication: ____

Medication: ____

Medication: ____

Dear Patient,

Congratulations! You have taken the first step to begin your recovery. It is very important to follow through and comply with your Doctor's prescribed plan of care. It is essential that you adhere to the frequency and duration (weekly visits x number of weeks) that your Doctor recommended for your particular condition.

Some individuals will experience increased soreness when they first begin physical therapy, but with continued treatment the soreness will generally "go away" and your condition will improve. If at any time you become concerned, your physical therapist is available to answer your questions during your visit here, or by phone or email.

Some days you might feel great and have NO pain. This is good because it means that your physical therapy plan is working; it does not mean that you should discontinue or stop your treatments before your script is completed. Our goal is to get you to a pain free status where every day will be pain free, and we want you to resume all of your normal daily activities. In order for you to receive the maximum benefits of physical therapy, you should follow your Doctor's orders just as you would for any medicine your Doctor may prescribe. If during the course of your treatment you feel that you have reached your maximum improvement, please consult with your Doctor or your Physical Therapist to discuss being discharged.

Please consult with your treating physical therapist immediately if you feel that physical therapy is not meeting your expectations. Some conditions are slower than others to realize noticeable improvement. Your therapist may be able to design a more aggressive approach to help you achieve quicker results.

In order for you to get the most from physical therapy you will need to attend all of your scheduled PT visits, be faithful to a home exercise program if you are given one and communicate with your therapist regularly about any changes in your condition.

Welcome to our family. We appreciate the trust and confidence that you and/or your physician have placed in us and we want you to know that we are here for you. If you are like the thousands of satisfied patients before you, you are going to absolutely love your physical therapy experience and positive outcome. If at any time you feel like there are areas of our service that can be improved, we would appreciate you notifying us immediately.

Sincerely,

Scott A. Humpal, P.T.

HUMPAL PHYSICAL THERAPY
SUMMARY NOTICE OF PRIVACY RACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our pledge to protect your privacy:

Humpal Physical Therapy is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Participant Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of Humpal Physical Therapy's disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information;
- to request that we communicate with you in a certain way or at a certain location;
- and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions necessary to run Humpal Physical Therapy and assure that our participants receive quality care;
- and as required or permitted by law.

There are additional situations where we may disclose medical information about you without your authorization, such as:

- for workers' compensation or similar programs;
- for public health activities (e.g., reporting abuse or reactions to medications);
- to a health oversight agency, such as the Texas Department of Health Services;
- in response to a court or administrative order, subpoena, warrant or similar process;
- to law enforcement officials in certain limited circumstances;
- to a coroner, medical examiner or funeral director.

Our Notice may be revised or updated from time to time. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices, your rights regarding you medical information, and pertinent contact information.

For further information about the full Notice of Privacy Practices, please contact: Humpal Physical Therapy's Privacy Officer at (361) 334-2317 ext.#1116. A complete version of this notice is available on our website at www.humpalphysicaltherapy.com

HUMPAL PHYSICAL THERAPY
ACKNOWLEDGEMENT OF
RECEIPT
OF SUMMARY NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (361) 334-2317 ext.#1116.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Humpal Physical Therapy provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The participant understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Humpal Physical Therapy has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
- Humpal Physical Therapy reserves the right to change the Notice of Privacy Practices.
- The participant has the right to request restrictions to the uses of their information but Humpal Physical Therapy does not have to agree to those restrictions.
- The participant may revoke this Consent in writing at any time and full disclosures will then cease.
- Humpal Physical Therapy may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

____
Name of Participant (print)

__________________________________ _____________
Signature of Participant Date

__________________________________ _____________
Signature of Participant Representative Date
(Required if participant is a minor or an adult who is unable to sign this form)

____
Relationship of Participant Representative to Participant Print Name