CHPT
Complete Hometown Physical Therapy

☐201A North Main St, Hallettsville, TX 77964 (361) 798-3500
☐105 Boehm Dr, Shiner, TX 77984 (361) 594-8301
☐206 Hwy 77A South, Yoakum, TX 77995 (361) 407-5091
www.completehometownpt.com

# Patient Demographic Sheet

**Referred by**: _____

**Last Name:** _____ **First Name:** _____

**Mailing Address:** _____ **Apt/Ste:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Gender:** _____ **Marital Status:** _____ **E-mail:** _____

**Employer:** _____ **Occupation:** _____

**Home Phone:**_____ **Work:**_____ **Cell:** _____

**Date of Birth:** _____ **SSN:** _____ **Driver's License #:**_____

**Emergency Contact:**

**1) Name** _____ **Phone** _____ **Relationship** _____

**2) Name** _____ **Phone** _____ **Relationship** _____

**Primary Insurance:** _____ **Policy ID #:** _____

**Group#:** _____ **Policy Holder Name:** _____

**Date of Birth:** _____ **SSN:** _____ **Employer:** _____

**Address (if different from Pt):** _____

**City** _____ **State:** _____ **Zip:** _____ **Relationship to Pt:** _____

**Are you covered by a secondary insurance? YES / NO**

**Secondary Insurance:** _____ **Policy ID #:** _____

**Group#:** _____ **Policy Holder Name:** _____

**Date of Birth:** _____ **SSN:** _____ **Employer:** _____

**Address (if different from Pt):** _____

**City** _____ **State:** _____ **Zip:** _____ **Relationship to Pt:** _____

- Please try to provide at least 24 hours notice if you must cancel or reschedule an appointment so that we may provide another patient with that appointment opportunity. Exceptions are for Monday appointments when 24 hour notice is not possible or when your appointment is the day after a holiday.

- I hereby give authorization for payment of medical and/or auto insurance benefits and/or legal settlement payments to be made directly to Complete Hometown Physical Therapy, and for any assisting therapist employed by or contracted with Complete Hometown Physical Therapy.

- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance, provided I am notified in advance that any proposed service or therapy/treatment/procedure may not be covered by patient's insurance provider(s).

- I understand that all copay, coinsurance and deductible amounts are due and payable at the time of service, unless a payment arrangement has been made with the billing. If the explanation of benefits from the insurer(s) shows a remaining patient balance due, the patient will be billed accordingly.

- In the event of a default in payment, the prevailing party in any lawsuit or mediation will be entitled to recover reasonable attorney fees and actual costs of collection.

- I hereby authorize Complete Hometown Physical Therapy to release any and all information necessary to secure payment of benefits to only those parties legally entitled to receive information for purposes of receiving payment of existing balances or for authorization for continuation of services as may be necessary or requested by the patient's insurer(s).

- I agree that a photocopy of this agreement shall be as valid as the original.

Thank you for you cooperation.

Patient (if minor – Parent or Legal Guardian) Signature: _____

Date: _____

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# Patient Medical History

Name: _____

Physician(s): PCP _____ Specialist _____

Are you currently receiving or recently received Home Health treatment? Yes / No
If yes, name of home health company that provided treatment _____

Please list all medications: _____

_____

**Have you had any of the following Medical or Rehabilitative Service for this Injury/Episode? Mark Yes to all that apply**

| | | | | | |
|---|---|---|---|---|---|
| Chiropractor | Yes | ☐ | CT Scan | Yes | ☐ |
| EMG/NCV | Yes | ☐ | General Practitioner | Yes | ☐ |
| Massage Therapy | Yes | ☐ | MRI | Yes | ☐ |
| Myelogram | Yes | ☐ | Neurologist | Yes | ☐ |
| Occupational Therapist | Yes | ☐ | Orthopedist | Yes | ☐ |
| Physical Therapist | Yes | ☐ | Podiatrist | Yes | ☐ |
| Emergency Room | Yes | ☐ | X-Rays | Yes | ☐ |

Other: _____

**General Health Information: Do you know or have you had ANY of the following? Mark Yes to all that apply.**

| | | | | | |
|---|---|---|---|---|---|
| Asthma, Bronchitis, or Emphysema | Yes | ☐ | Severe or Frequent Headaches | Yes | ☐ |
| Shortness of Breath/Chest Pain | Yes | ☐ | Vision or Hearing Difficulties | Yes | ☐ |
| Coronary Heart Disease or Angina | Yes | ☐ | Numbness or Tingling | Yes | ☐ |
| Pacemaker | Yes | ☐ | Dizziness or Fainting | Yes | ☐ |
| High Blood Pressure | Yes | ☐ | Ringing in ears | Yes | ☐ |
| Heart Attack or Surgery | Yes | ☐ | Weakness | Yes | ☐ |
| Stroke/TIA | Yes | ☐ | Weight Loss/Energy Loss | Yes | ☐ |
| Blood Clot/Emboli | Yes | ☐ | Hernia | Yes | ☐ |
| Epilepsy/Seizures | Yes | ☐ | Tuberculosis | Yes | ☐ |
| Thyroid Trouble/Goiter | Yes | ☐ | Allergies | Yes | ☐ |
| Anemia | Yes | ☐ | Any pins or metal implants | Yes | ☐ |
| Infectious Disease | Yes | ☐ | Joint Replacement | Yes | ☐ |
| Diabetes | Yes | ☐ | Neck injury/surgery | Yes | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| Cancer or Chemotherapy/Radiation | Yes | ☐ | Shoulder injury/surgery | Yes | ☐ |
| Arthritis/Swollen Joints | Yes | ☐ | Elbow/Hand injury/surgery | Yes | ☐ |
| Osteoporosis | Yes | ☐ | Back injury/surgery | Yes | ☐ |
| Gout | Yes | ☐ | Knee injury/surgery | Yes | ☐ |
| Sleeping problems/difficulties | Yes | ☐ | Leg/Ankle/Foot injury/surgery | Yes | ☐ |
| Emotional/Psychological Problems | Yes | ☐ | Are you Pregnant | Yes | ☐ |
| Bowel or Bladder Problems | Yes | ☐ | Do you Smoke | Yes | ☐ |

List any other information that would assist us in your care: _____

_____

Based upon your awareness, what are your expectations/goals in this program? _____

_____

Patient/Guardian Signature: _____ Date: _____

# RECEIPT OF NOTICE OF PRIVACY PRACTICES
# WRITTEN ACKNOWLEDEMENT FORM

I, _____, have received a
Patient Name

copy of the Notice of Privacy Practices for Complete Hometown Physical Therapy.

_____ _____
Signature of Patient or Legal Guardian Date

**FOR OFFICE USE ONLY**

Complete Hometown Physical Therapy was unable to obtain acknowledgement because:

- ❑ Emergency
- ❑ Patient Non-Responsive
- ❑ Patient Sedated
- ❑ Patient Confused/Disoriented
- ❑ Patient Refused – Reason _____
- ❑ Other _____

_____ _____
Staff Signature