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
- 607 S. Esplanade St, #4, Cuero, TX 77954 (361) 418-0033

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? (circle one)

Chiropractor	Yes	No	CT Scan	Yes	No
EMG/NCV	Yes	No	General Practitioner	Yes	No
Massage Therapy	Yes	No	MRI	Yes	No
Myelogram	Yes	No	Neurologist	Yes	No
Occupational Therapist	Yes	No	Orthopedist	Yes	No
Physical Therapist	Yes	No	Podiatrist	Yes	No
Emergency Room	Yes	No	X-Rays	Yes	No

Other: _____

General Health Information: Do you know or have you had ANY of the following? Circle all that apply.

Asthma, Bronchitis, or Emphysema	Yes	No	Severe or Frequent Headaches	Yes	No
Shortness of Breath/Chest Pain	Yes	No	Vision or Hearing Difficulties	Yes	No
Coronary Heart Disease or Angina	Yes	No	Numbness or Tingling	Yes	No
Pacemaker	Yes	No	Dizziness or Fainting	Yes	No
High Blood Pressure	Yes	No	Ringing in ears	Yes	No
Heart Attack or Surgery	Yes	No	Weakness	Yes	No
Stroke/TIA	Yes	No	Weight Loss/Energy Loss	Yes	No
Blood Clot/Emboli	Yes	No	Hernia	Yes	No
Epilepsy/Seizures	Yes	No	Tuberculosis	Yes	No
Thyroid Trouble/Goiter	Yes	No	Allergies	Yes	No
Anemia	Yes	No	Any pins or metal implants	Yes	No
Infectious Disease	Yes	No	Joint Replacement	Yes	No
Diabetes	Yes	No	Neck injury/surgery	Yes	No
Cancer or Chemotherapy/Radiation	Yes	No	Shoulder injury/surgery	Yes	No
Arthritis/Swollen Joints	Yes	No	Elbow/Hand injury/surgery	Yes	No
Osteoporosis	Yes	No	Back injury/surgery	Yes	No
Gout	Yes	No	Knee injury/surgery	Yes	No
Sleeping problems/difficulties	Yes	No	Leg/Ankle/Foot injury/surgery	Yes	No
Emotional/Psychological Problems	Yes	No	Are you Pregnant	Yes	No
Bowel or Bladder Problems	Yes	No	Do you Smoke	Yes	No

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 ACKNOWLEDGMENT 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

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accounting Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, for other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Complete Hometown Physical Therapy, LLC**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law-enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right amend or submit corrections to your protected health information
- The right to receive accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of the notice

Complete Hometown Physical Therapy, LLC Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting The Privacy Officer, Complete Hometown Physical Therapy LLC, P. O. Box 248, Hallettsville, Texas 77964. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer Mary Ann Poole
Complete Hometown Physical Therapy
P. O. Box 248
Hallettsville, TX 77964

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practice is:

Privacy Officer Mary Ann Poole
Complete Hometown Physical Therapy
P. O. Box 248
Hallettsville, TX 77964
361-772-1098

Effective Date
This notice is effective on or after Jan. 1, 2013.