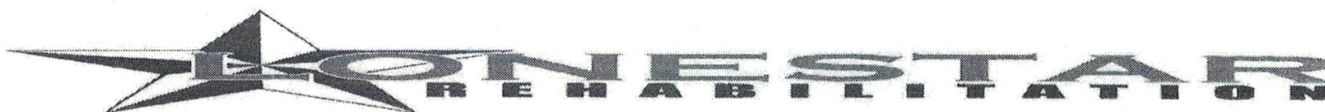

Patient Registration

Personal Information				
Social Security Number:			Date of Birth:	
Last Name:			First Name:	MI:
Address:				
City:	State:	Zip:	Home Phone:	
Driver's license #:			Work Phone:	
Sex: ❑ Male ❑ Female			Cell Phone:	

Insured Party/Responsible Party (leave blank if same as patient)			
Social Security Number:	Date of Birth:		
Last Name:	First Name:		MI:
Address:			
City:	State:	Zip:	
Home Phone:	Work Phone:		
Sex: ❑ Male ❑ Female	Relationship to Patient:		

Employer Information			Insured's Employer Information (Leave blank if same as patient)		
Employer Name:			Employer Name:		
Employer Address:			Employer Address:		
City:	State:	Zip:	City:	State:	Zip:

Emergency Contact Information:		
Last Name:	First Name:	MI:
Relationship: ❑ Spouse ❑ Parent ❑ Friend ❑ Other:		Cell Phone:
Home Phone:	Work Phone:	

Other Information		
Date OF Injury Onset:	Accident: ❑ No Accident ❑ Auto ❑ Work ❑ Other:	
Description of Injury:		If Auto Accident, list State where accident occurred:

Patient Certification and Signature	
I certify that all of the information provided herein is true and correct.	
Patient/Guardian Signature:	Date:

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Patient Medical History

Patient Name:	SS #:
Reason for Physical Therapy:	Date of injury:
Have you had treatment for this before? ❑ Yes ❑ No Treatment received: Previous Treatment: ❑ Successful ❑ Unsuccessful	If Yes, When: Who is your current primary care doctor?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
High Blood Pressure			Pain with Cough			Kidney Problems		
Heart Attack			Fever			Open Wounds		
Heart Disease			Cancer			Current Infection(s)		
Stroke			Seizures			Hypersensitive to Heat/ Cold		
Diabetes			Night Sweats			Allergies		
Spinal Fusion			Unexplained Wt. Loss			Metal in Body		
Pace Maker			Nausea			Thyroid Problems		
Presently Pregnant			Dizziness			Previous Fractures		
Asthma			Falls			Osteoporosis		
Hernias			Arthritis			Depression		
Hemorrhoids			Vascular Disease			Anxiety		
Tuberculosis			Headaches			Substance Abuse		
Previous Surgeries			Abnormal Bladder			Night Pain		

If you answered yes to any of the above, please explain and give approximate dates:

Are you currently taking any medications? ❑ No ❑ Yes, List Medications and specify condition:

Do you require assistance completing this form? ❑ No ❑ Yes

The above information is correct to best of my knowledge.

Patient/Guardian Signature:	Date:
Therapist Signature:	Date:

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NOTICE OF PRIVATE PRACTICES PATIENT AKNOWLEDGEMENT

I __________________________ have received, or been offered, this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice. My individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to protect the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that the practice is permitted to make for each of the following purposes: treatment, payment and healthcare operations.
- A description of each of the purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notices of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of it's Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practices current Notice of Privacy Practices on request. ✗ __________________________ ____________

Signature Date

My Health Care Information

I, __________________________, hereby authorize the release of information as indicated:

1) _____ I authorize disclosure of health care information (related to my medical history, diagnosis, treatment or prognosis) to my doctor and or health insurance company.

Observation Consent

2) _____ I hereby authorize to be observed by volunteer students. (This is an educationally based facility containing many observers hoping to gain experience for their career in physical therapy. It would be greatly appreciated by the students and staff to be given the opportunity to observe and learn from your physical therapy experience).

✗ __________________________ ______ ✗ __________________________ ______

Signature of Patient or Legal Guardian Date Signature of Witness Date

PATIENT RELEASE

Patient Name:	
Release of Information	
All information provided herein is true and correct. I authorize LoneStar Rehabilitation to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. I give permission to LoneStar Rehabilitation to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment. Information without patient identifiers may be used for quality assurance purposes. I hereby consent to treatment. I have read and understand the above release.	
Patient or Guardian Signature:	**Date:**

Assignment of Benefits/Third Party Payment Authorization	
I hereby authorize payment directly to LoneStar Rehabilitation for services rendered. This is a direct assignment of my rights and benefits under this agreement. A photocopy of this agreement shall be considered as effective and valid as the original. I Authorize Lonestar Rehabilitation to directly bill my health plan or third-party payor for services rendered to me by Lonestar Rehabilitation. I also authorize any third party-payor through which I may have benefits to make payment directly to Lonestar Rehabilitation for physical therapy services rendered. I understand and agree that Lonestar Rehabilitation is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.	
Patient or Guardian Signature:	**Date:**

Payment Guarantee	
I agree to pay LoneStar Rehabilitation for the services rendered to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where a law or insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The benefit verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of LoneStar Rehabilitation.	
Patient or Guardian Signature:	**Date:**

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Consent to Treatment

My diagnosis, evaluation findings, the Therapist's recommendations regarding treatment, the expected benefits or goals of treatment, and reasonable alternatives to recommended treatment, have all been explained to me and my questions about care answered to my satisfaction. I consent to the recommended course of treatment.

Patient/Guardian Signature ______________________ Date ______________

Therapist Signature ______________________ Date ______________

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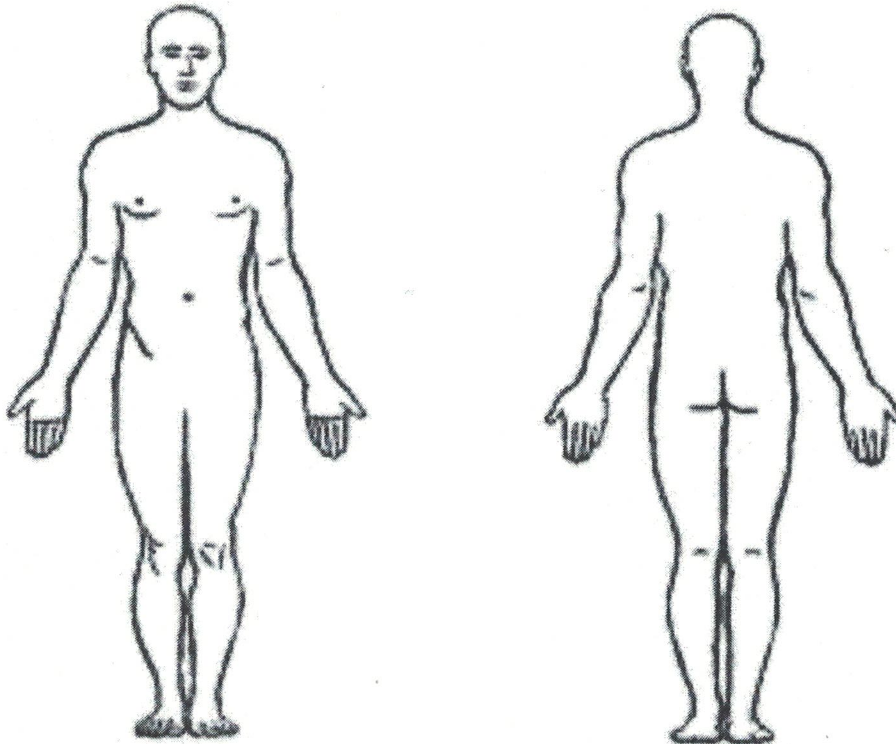
Shade in the areas of your symptoms over the past 30 days



Who referred you to physical therapy? ______________________________
Describe your symptoms over the past 30 days: ______________________________
____

When and how did your injury occur?______________________________
____

____

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