

Dear Patient,

We are very excited to welcome you to Promotion Physical Therapy! We want you to know how much we appreciate the chance to be your physical therapy provider. Our clinic is focused on providing you the highest quality physical therapy available.

During your first visit, the physical therapist will examine you based on the prescription written by your doctor and make an assessment of your physical condition. They will explain to you their findings and the appropriate treatment for your condition. Then your treatment will begin so we can get you feeling better as soon as possible.

While being treated by our staff, please do not hesitate to ask questions, make comments, and share your concerns so that we may make your physical therapy treatment as successful as possible. Be sure to wear comfortable clothes and shoes. You may want to bring water to keep yourself well hydrated during your treatments.

Enclosed you will find a New Patient Packet. Please complete all the forms and return them to the front desk along with your photo identification and your health insurance card(s) if applicable.

Thank you for choosing Promotion Physical Therapy! We look forward to serving you.

Sincerely,

Promotion Physical Therapy, P.C.

Visit us at: www.promotionpt-sa.com

North Central: 15614 Huebner Road, Ste. 115, San Antonio, TX 78248

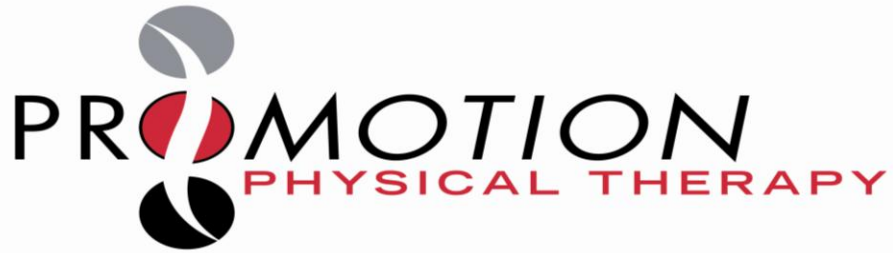
Westover Hills: 10415 State Highway 151, Ste. 101, San Antonio, TX 78251

Medical Center: 9502 Huebner Road, San Antonio, TX 78240

O: (210) 479-3334 F: (210) 479-3338

O: (210) 647-9970 F: (210) 647-7229

O: (210) 478-5486 F: (210) 478-5388



PATIENT INFORMATION:

Name: First: _____ Middle: _____ Last: _____

Address: _____ Home Phone: (_____) _____

City/State/Zip: _____ Mobile Phone: (_____) _____

Marital Status: _____ Email: _____

Sex: M / F Date of Birth: _____ Social Security Number: _____

Emergency Contact: _____ Phone: (_____) _____

PATIENT/GUARANTOR EMPLOYMENT INFORMATION:

Employer Name: _____ Work Phone: (_____) _____

Employer Address: _____ Occupation: _____

City/State/Zip: _____

Full Time Part Time Unemployed Student Retired, How Long? _____

REFERRING PHYSICIAN:

Name: _____ Phone: (_____) _____

ADDITIONAL INFORMATION:

1. Is this a work related injury? Yes No If yes, what was the date of injury? _____

2. Is this case currently involved in litigation? Yes No Attorney's Name: _____
Attorney's Phone: (_____) _____ Attorney's Fax: (_____) _____

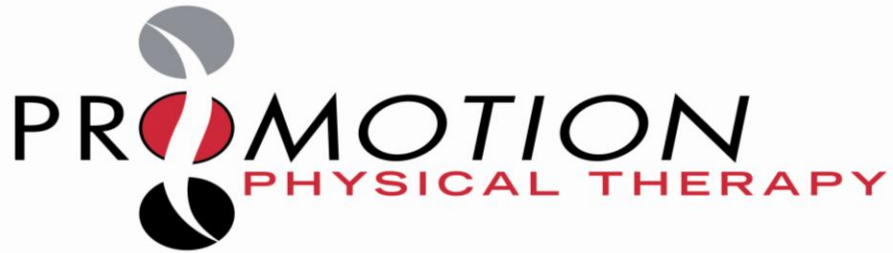
3. Have you received any physical therapy for any condition this year? Y N If yes, how many visits? _____

4. Are you currently enrolled in Home Health? Yes No

5. Have you had surgery for this condition? Yes No If yes, what was the date of the surgery? _____

6. How did you hear about Promotion Physical Therapy?

Doctor Friend Mail Yellow Pages Other: _____



INSURANCE INFORMATION

INSURED NAME

Last: _____ First: _____ MI: _____

Social Security #: _____ - _____ - _____ DOB: _____ / _____ / _____

Patient relationship to above: Self Spouse Child Other: _____

PRIMARY INSURANCE

Primary Insurance: _____

ID Number: _____ Group Number: _____

SECONDARY INSURANCE

Secondary Insurance: _____

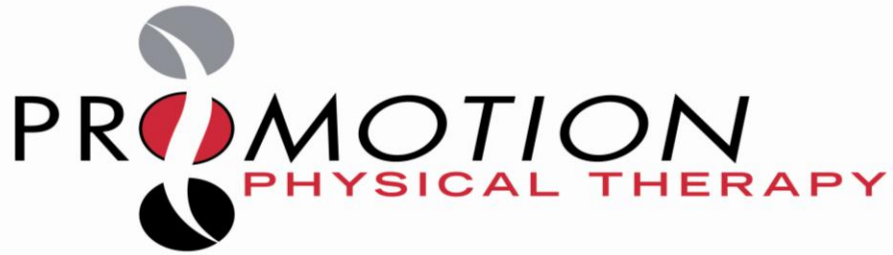
ID Number: _____ Group Number: _____

Is the insured name on the secondary the same as the first? Y N

If No, then:

Last: _____ First: _____ MI: _____

Social Security #: _____ - _____ - _____ DOB: _____ / _____ / _____



Past Medical History

Do you currently have or have you ever had any of the following:

	Yes	No		Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/ Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Attack	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any surgical implants?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any current or past health or medical problems that are not listed above? _____

Please list all surgeries and the approximate date of the operation: _____

Please list all medications that you are currently taking: _____

Do you smoke? Y or N If you do smoke, please try to refrain from smoking for 2 hours before and after each of your appointments to significantly help the healing process.

Name: _____

Signature: _____

Date: _____



PATIENT AUTHORIZATION

Consent for Treatment and Authorization to Release Information

I hereby authorize PROMOTION PHYSICAL THERAPY, P.C., to provide any physical therapy services or related services as deemed necessary by the physical therapist(s). I consent and authorize PROMOTION PHYSICAL THERAPY, P.C., to release all information contained in my medical and financial records, including diagnosis and test results, to:

1. any doctor or other health care provider involved in my care
2. my insurance company or health plan including Medicare
3. any person or entity responsible for paying or processing for payment of any portion of my healthcare bill(s)
4. governmental or accrediting agencies
5. entities utilizing this information for quality management, peer review and or outcome analysis
6. any other person or entity as required or allowed by state and/or federal law

This consent applies to all records created in the course of and relating to this healthcare. To provide the practitioners who will treat me during my care with an access to my prior medical history, I also consent and authorize any health care provider to release medical information contained in my medical records from prior treatment that is relevant to my current care and treatment.

If I am the patient or the patient's legal guardian, I also consent to release billing information and medical records to the patient's primary care physician (PCP) and his/her medical group. This release shall remain valid until I notify the company, in writing, of my desire to revoke it.

Assignment of Insurance Benefits

I hereby authorize any and all insurance carriers, Medicare, attorneys, agencies, governmental departments, companies, individuals, and/or legal entities ("payers") to pay directly to PROMOTION PHYSICAL THERAPY, P.C., benefits due me, if any, by reason of services described in the statement rendered.

Initials

Consent for Testing

I agree that if a company employee or healthcare worker is exposed to my blood that I grant permission to the company to have my blood drawn and to run tests for Hepatitis and/or the HIV/AIDS virus. The cost will not be my responsibility and the results will not be part of my medical record.

Personal Valuables

I hereby release PROMOTION PHYSICAL THERAPY, P.C., and its associates of any and all responsibility for loss or damage to personal property, including but not limited to clothing, money, or other valuables kept in my possession or brought in by me or anyone with me during my care.

Printed Name

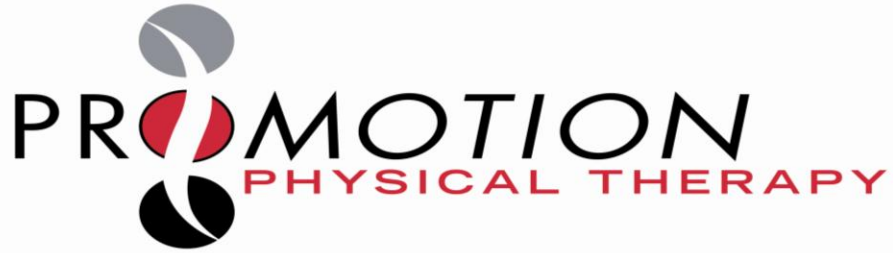
Signature

Date

Printed Witness

Signature

Date



Acknowledgement of Review of Notice of Privacy Practices

I have been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Name of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

Description of Personal Representative's Authority

FOR COMPANY USE ONLY

Refusal to Sign Acknowledgement of Review of Notice of Privacy Practices

The following patient has been offered a copy of the Notice of Privacy Practices but has refused to sign the Acknowledgement of Review of Notice of Privacy Practices:

Patient: _____ Date _____

Reason (if given by patient): _____

Employee Signature: _____ Date _____



CANCELLATION AND NO-SHOW POLICY

PROMOTION PHYSICAL THERAPY, P.C., strives to provide each patient with the highest quality care while accommodating your schedule. Therefore, we reserve specific time-allotments for each patient. It is critical for you to consistently attend your scheduled appointments in order to achieve the goals that you, your physician, and your physical therapist want you to achieve.

We respectfully request 24-hours advanced notice of any appointment cancellation. If we do not receive advanced notice of a cancellation, our ability to meet the scheduling needs of our other patients is limited. **If you cancel without a 24-hour notice, you will be charged a \$25.00 Cancellation Fee.** In addition, if you do not keep your appointments, **your treatment program will be terminated after the second consecutive NO-SHOW or third consecutive CANCELLATION** and your physician will be notified immediately. We recognize legitimate reasons for missing appointments and keep accurate records of those occurrences, but we need your cooperation in contacting our office as soon as possible when you will be unable to keep your appointments.

WORKER'S COMPENSATION PATIENTS

All cancellations and NO-SHOWS will be documented in your medical record and appropriately reported to your physician, employer and adjuster. **Be advised, every appointment for which you do not show will be reported that same day.**

Thank you for your cooperation and consideration of our staff and other patients.

I have read the Cancellation and No-show Policy of PROMOTION PHYSICAL THERAPY, P.C. I understand its contents and agree to the terms above.

Printed Name

Signature

Date