TRIO REHABILITATION & WELLNESS SOLUTIONS

# NEW PATIENT INFORMATION

Name

Address

City/State Zip

GENDER: ❍ MALE ❍ FEMALE

DOB SSN

Caretaker/Interpreter

Referring Doctor

Dr. Phone Number

Primary Care Dr.

Dr. Phone Number

## Please select two preferred contact methods

❍ HOME PHONE

❍ CELL PHONE

❍ TEXT MESSAGE

❍ EMAIL

Emergency Contact

Relation To You phone

Body Part Affected

Have Your Had Physical Therapy This Year? ❍ YES ❍ NO

Date Of Onset/Injury

IS INJURY FROM: ❍ AUTO ❍ WORK ❍ OTHER

## Insurance Policy Information

Insurance Company

Identification Number

Group Number

Primary Insured Name

Relation To Patient

Primary Insured DOB

❍ Insurance Card Provided

## Secondary Health Insurance

Insurance Company

Identification Number

Group Number

Primary Insured Name

Relation To Patient

Primary Insured DOB

❍ Insurance Card Provided

## How did you hear about us?

❍ HEALTHCARE PROVIDER ❍ FAMILY/FRIEND

❍ INTERNET ❍ SOCIAL MEDIA

❍ EVENT ❍ OTHER_____

## Patient Agreement - Please Read Carefully

I authorize treatment of the patient named above and agree to pay all charges for such treatment that may or may not be covered by my insurance. I also authorize the provider to release any information to referring/consulting physicians or other health care providers that may be necessary to facilitate care. I hereby authorize my insurance benefits to be paid directly to Trio Rehabilitation & Wellness Solutions. I certify that a copy of this agreement shall be valid as the original.

Patient or Legal Guardian Signature Date

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# FINANCIAL POLICY - READ CAREFULLY AND SIGN

It is your responsibility to know the limitations and restrictions of your insurance company regarding physical therapy. By signing below you hereby authorize your insurance benefits to be paid directly to Trio Rehabilitation & Wellness Solutions. You are responsible for paying your balance regardless of your insurance company's payments. **Copays are due at the time of service.** If your insurance company does not cover therapy and you choose to pay out of pocket for treatment, your balance is due at the time of your appointment.

In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and collection fees. If legal action is taken against your account, you agree to pay all reasonable attorney fees, filing fees and any other costs associated with this action. Checks returned without sufficient funds will be charged a $35.00 fee.

Patient or Legal Guardian Signature Date

**Missed Appointments & Cancellations:** appointments not kept or cancelled without 24 hours notice prior to the scheduled appointment time will be charged a **$50.00 cancellation fee.** These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. If you miss 3 appointments without proper notice, all future appointments will be cancelled.

Patient or Legal Guardian Signature Date

## PRIVACY POLICIES STATEMENT/HIPAA

You have the opportunity to review and question our privacy policies statement at your request. This statement outlines our policies that protect your privacy. We will release your personal health information for billing purposes to be reimbursed for services rendered or to facilitate your care with another of your health care providers. You may request (in writing) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for your balance and it will be your responsibility to submit claims to your insurance carrier for reimbursement.

Patient or Legal Guardian Signature Date

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# PATIENT HEALTH QUESTIONNAIRE

NAME _____ WEIGHT _____ HEIGHT _____ AGE _____ GENDER _____

CHECK ALL BOXES THAT APPLY

**Have you or any immediate family member ever been told you have:**

| | YOU | FAMILY |
|---|---|---|
| Dementia | ❍ | ❍ |
| Fibromyalgia | ❍ | ❍ |
| Fracture | ❍ | ❍ |
| Cancer | ❍ | ❍ |
| High Blood Pressure | ❍ | ❍ |
| Diabetes | ❍ | ❍ |
| Heart Disease | ❍ | ❍ |
| Angina/Chest Pain | ❍ | ❍ |
| Stroke | ❍ | ❍ |
| Arthritis | ❍ | ❍ |
| Parkinsons Disease/ Movement Disorder | ❍ | ❍ |

**Do you have a history of:**

- ❍ Shortness of Breath
- ❍ Allergies
- ❍ Asthma
- ❍ Bronchitis
- ❍ Kidney Disease/Stones
- ❍ Polio
- ❍ Emphysema
- ❍ Anemia
- ❍ Rheumatic Fever
- ❍ Ulcers

**With current problem do you experience:**

- ❍ Nausea/Vomiting
- ❍ Fever/Chills/Sweats
- ❍ Unexplained Weight Change
- ❍ Numbness or Tingling
- ❍ Bowel or Bladder Changes
- ❍ Dizziness
- ❍ Pain
- ❍ Headaches
- ❍ Muscular Weakness
- ❍ Surgery

**For this problem have you received treatment from:**

- ❍ Orthopedist
- ❍ Physiatrist
- ❍ Neurosurgeon
- ❍ Chiropractor
- ❍ Massage Therapist
- ❍ Other _____
- ❍ Osteopath
- ❍ Acupuncturist
- ❍ Psychologist
- ❍ Other Physical Therapist

**Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections?**

❍ NO ❍ YES

Describe: _____

**How often do you feel stress is a significant factor in your life?**

❍ Never ❍ Seldom ❍ Regularly ❍ Always

Date of last complete physical examination?

_____

**Do you smoke?** ❍ No ❍ Yes

How many packs? _____

For how long? _____

**Do you drink alcohol?** ❍ No ❍ Yes

# of drinks per week? _____

**List regular exercise/activity:** _____

**Other comments:** _____

18 Scenic Loop Rd. Suite 200-A, Boerne, TX 78006 | 830.755.6091 | **TRIOrehab.com** | info@TRIOrehab.com

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# Trio Rehab

Patient Name DOB

Allergies:

| Medication | Dose | Date Taken | Date Started | Reason for Taking | Who told me to take this? |
|---|---|---|---|---|---|
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# CONSENT TO PHOTOGRAPH

_____
Patient

I, _____, a current patent of Trio Rehabilitation & Wellness Solutions hereby authorize the attending therapist or other designated person to:

1. Photograph me for identification purposes. ❑ Yes ❑ No

2. Photograph appropriate parts of my body in order to provide supporting documentation for my medical condition. (I understand that any photographs taken will be placed in and remain part of my medical record.)

3. Photograph me for the purpose of (specify): ❑ Yes ❑ No

_____

_____

_____

❑ I affirm that I have read this contract to likeness and release, and I fully understand the consent, meaning and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

_____
Patient Name (Written Out)

_____ _____
Patient or Legal Guardian Signature Date