FORT WORTH
Head, Neck, & Jaw

PATIENT INFORMATION **Date:** ___/___/___

Name: _____ _____ _____ **Soc Sec #:** ___-___-____
Last Name First Name Initial

Address: _____ **City/State/Zip:** _____

Home Phone: (___)___-____ **Work Phone:** (___)___-____ **Cell Phone:** (___)___-____

E-Mail Address: _____ **Cell Phone Provider:** _____

Would you like to receive appointment reminders by: ☐ **Email** ☐ **Text Message**

Sex: Pick One **Birthdate:** ___/___/____ **Age:** ____ ☐**Single** ☐**Married** ☐**Widowed** ☐**Separated** ☐**Divorced**

In case of an emergency, please notify: _____ (___ ***Phone:*** (___)___-____

Patient Employer: _____ **Occupation:** _____

Employer Address: _____ **City/State/Zip:** _____

Tricare patients:

Sponsor Name: _____ **Sponsor Birthdate** ___/___/____

Sponsor Employer: _____ **Sponsor Soc Sec #:** ___-___-____

Referring Physician: _____ Primary Physician: _____

Approximate Injury Date: _____

Who may we thank for this referral? _____

Assignment, Release and Consent:

I, the undersigned, certify that I (or my dependent) has insurance coverage with _____ and assign directly to **Fort Worth Head, Neck, & Jaw** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Fort Worth Head, Neck, & Jaw** to release all information necessary and use this signature to secure the payment of benefits. I further certify that the above patient information and history is accurate and complete. I understand and agree to abide by the cancelation policy set forth by **Fort Worth Head, Neck, & Jaw** as posted. I authorize **Fort Worth Head, Neck & Jaw** to use any of the means of contact listed above to communicate with me, including but not limited to phone calls, voicemail, email, and text message unless otherwise indicated. I hereby authorize and give my consent for treatment of the condition for which my physician referred me. Outcomes cannot be guaranteed, however, if you feel that you did not get the best service/ care possible, let us know and we will refund your payment for

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (if applicable) Date

Patient Name: _____

Pain level 0-10 (0 = no pain, 10 = excruciating pain, call 911):

Current: Current Pain (0-10)

Worst: Worst Pain (0-10)

Best: Best Pain (0-10)

Location of pain on body: _____

When and how did your pain begin? _____

_____

Pain relieved/better with: _____ Pain worse with: _____

Have you received physical, occupational, speech, chiropractic therapy or home health services in the past year? ☐ **Yes** ☐ **No**

If for this injury, what was the result? _____

Are you currently receiving any Home Health services? Select One

Presently Working: Select One Hand Dominance: Select One

Current job status/duties: ☐ Normal ☐ Modified duty ☐ Off work ☐ Unemployed ☐ Retired

Medical History – Please indicate if you have had any of the following and dates if applicable:

Heart Problems	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Allergies	☐ Y	☐ N
Lung Problems	☐ Y	☐ N	Back/Neck Problems	☐ Y	☐ N
Asthma	☐ Y	☐ N	Shortness of Breath	☐ Y	☐ N
Dizziness	☐ Y	☐ N	Chest Pain	☐ Y	☐ N
Stroke	☐ Y	☐ N	Traumatic Head Injury	☐ Y	☐ N
Blood in Urine	☐ Y	☐ N	Hernia	☐ Y	☐ N
Cancer	☐ Y	☐ N	Arthritis	☐ Y	☐ N
Seizures	☐ Y	☐ N	Osteoporosis	☐ Y	☐ N
Pace Maker	☐ Y	☐ N	Other: _____		

Height: _____ Weight: _____ Smoker: ☐ Y ☐ N

Current Medications: _____

_____

Brief medical/surgical history (including date, if applicable): _____

_____

_____

Texas Board of Physical Therapy Examiners

333 Guadalupe, Ste 2-510 ***512/305-6900 • 512/305-6951 fax***
Austin, Texas 78701-3942 ***http://www.ptot.texas.gov***

Physical Therapy Treatment without Referral Disclosure

Please read carefully and acknowledge below:

I understand that physical therapy treatment without a referral will be based on the physical therapist's examination and evaluation of my current condition which may result in identification of movement and mobility dysfunction.

I understand that the physical therapist will not diagnose an illness or disease, and that physical therapy is not a substitute for a medical diagnosis.

I understand that if a medical diagnosis has already been established by a qualified healthcare practitioner, the physical therapist will take it into consideration during the evaluation process.

I understand that the physical therapy plan of care developed by the physical therapist may not be based on radiological imaging.

I understand that if images have previously been obtained, the physical therapist may use the information as part of the evaluation process.

I understand that if the physical therapist identifies a need for radiological imaging, the physical therapist may recommend that radiological imaging be obtained.

I understand that my health insurance may not cover physical therapy services if provided without a referral from a qualified healthcare practitioner.

I acknowledge that I have received the above disclosure.

Patient Name (print): _____

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Print Name and Relationship to Patient

Approved by the Texas Board of Physical Therapy Examiners – 10/11/2019

FORT WORTH
Head, Neck, & Jaw

No-Show / Cancellation Policy

At Fort Worth Head, Neck, and Jaw, we want you to get the most out of your physical therapy visits. Your therapist will recommend a specific number of visits per week for your program. A recent study has **shown that patients who adhere to their physical therapy plan of care increase their ability to have success from physical therapy by 93%.** Even one missed visit can significantly decrease your success and result in a more chronic problem. We strongly stress the importance of keeping all scheduled appointments to achieve your personal physical therapy goals.

Helping each and every patient get the results they need is very important to Fort Worth Head, Neck, and Jaw. Our schedule is very full and certain time slots are not always available to patients who need them. For this reason we have a 24-hour cancellation policy in effect. If you cannot make a scheduled appointment, for any reason, we require 24 hours' notice of the cancellation. **When you call we will assist you in rescheduling this appointment because getting you results is our main goal.**

Please read the following policy to better help us, help you.

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.

2. We require that you cancel any appointment that you cannot make with no less than 24 hours' notice. We will get you rescheduled at that time. If you know you cannot make your appointment and it is after our business hours, please note that you can still call as we roll our phones every night and will receive your message. Calling after hours and leaving a message the day before is better than calling the morning of your appointment.

3. While we understand that illness can strike at anytime, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.

4. For all appointments, we expect that you will arrive on time, dressed for your session, and ready to begin at your scheduled treatment time.

5. While traffic can be unpredictable, we expect that you will call us immediately if you are running late for your scheduled appointment so we can be prepared for your late arrival.

6. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.

7. **Please note, we charge a missed visit fee for no-shows and cancellations with less than 24 hours notice. This amount is your responsibility as insurance will not cover a missed visit fee. This fee is $40 if canceled without 24 hour notice, and $165 for no-shows. To avoid the cancellation and no-show fee, call the office to reschedule any appointments you cannot attend 24 hours in advance.**

8. **After the 1st cancelled appointment without a 24-hour notice, all following cancelled appointments may result in being charged $165, the full amount of a physical therapy session. Appointments that are No Showed may result in being charged $165 and patients are subject to being discharged after the 3rd No Show at the office's discretion.**

Thank you for reviewing this policy. We require patients to keep a card on file and you agree for the card to be charged for outstanding balances or Cancellation/No Show fees. Please sign and return the signed copy and keep a copy for your records. We look forward to working with you to meet your physical therapy goals.
I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

Patient Signature: _____ Patient Name: _____ Date: _____