



Bulverde Physical Therapy & Wellness Center

21200 Hwy. 46 West; Spring Branch TX 78070

(830)980-4055 Phone (830)438-4085 Fax



Patients Name: _____ Date: _____

Address: _____
Street City State Zip

Home #: _____ Mobile #: _____ Other #: _____

SS #: _____ Drivers License: _____ DOB: _____

Employer Name: _____ Phone #: _____

Address: _____
Street City State Zip

Occupation: _____

Primary Insurance: _____ Policy: _____

Group Policy #: _____ Insured Name: _____

Insured SS #: _____ DOB: _____ TDL #: _____

Relationship to Insured: Self Spouse Dependent

Secondary Insurance: _____ Policy: _____

Group Policy #: _____ Insured Name: _____

Insured SS #: _____ DOB: _____ TDL #: _____

Relationship to Insured: Self Spouse Dependent

Emergency Contact: _____ Relationship: _____

Phone #: _____ Mobile #: _____ Other #: _____

Authorization: I hereby authorize the provider of services the right to release medical information for insurance purposes, to receive direct payment of benefits for services rendered and for medical purposes. I understand that I am responsible for any medical expenses not covered by insurance.

Please Sign: _____ Date: _____

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Health Screening



Name:	Date of Birth:	/	/
Physician's Name:	Sex:	Male	Female
Current Medications:			
Have you had, or are you receiving any Home Health Services within the last six months?		If yes, When:	
Do you have now, or have you had in the past:		CIRCLE ONE	
Heart Problems		YES	NO
TMJ Disorder		YES	NO
Hepatitis (type)		YES	NO
Heart Surgery (type)		YES	NO
Angina		YES	NO
High Blood Pressure		YES	NO
High Blood Cholesterol		YES	NO
Aneurysm		YES	NO
Stroke		YES	NO
Head Injury		YES	NO
Breathing or Lung Problems		YES	NO
Diabetes		YES	NO
Thyroid Condition		YES	NO
Osteoporosis		YES	NO
Arthritis		YES	NO
Fibromyalgia		YES	NO
Lupus		YES	NO
Muscle, Joint, Spine Disorder		YES	NO
Hernia		YES	NO
Malignancy/ Cancer		YES	NO
Joint Replacement		YES	NO
Recent Bone Fracture		YES	NO
Pregnancy (now or last 3 months)		YES	NO
Kidney Problems		YES	NO
Blood Disorders		YES	NO
Chronic Headache		YES	NO
Parkinson's/ Neurological Disorder		YES	NO
List all surgeries:			

I understand that any evaluation or physical therapy has an associated risk. The risk can vary from minor strains and sprains to major injuries to sudden death. I have provided accurate and true information on this health questionnaire and have supplied any possible problems or limitations not listed on the questionnaire. I assume the risk for my health.

Signature

Date



Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, “I” and “my” refer to the patient,

and “Physical Therapy” refers to “Bulverde Physical Therapy & Wellness Center”.

I consent to the use or disclosure of my protected health information by Physical Therapy for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Physical Therapy. I understand that analysis, diagnosis or treatment of me by Physical Therapy may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Physical Therapy is not required to agree to the restriction that I may request. However, if Physical Therapy agrees to a restriction that I request, the restriction is binding on Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physical Therapy has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to the past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices or Physical Therapy and understand that I have a right that Notice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Physical Therapy. The Notice of Privacy Practices for Physical Therapy is also posted in the waiting room at [insert address of Chiropractic practice]. This Notice of Privacy Practices also describes my rights and duties of the Physical Therapy with respect to my protected health information.

Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name or Patient

Date of Signing

Description of Personal Representative’s Authority

21200 Hwy. 46 W ~ Spring Branch, TX 78070 ~ phone - 830-980-4055 ~ fax - 830-438-4085
ASSIGNMENT OF PROCEEDS, CONTRACTUAL, LIEN, AND AUTHORIZATION
(“Agreement”)

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/ or other legal entities (“payers”), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illness, past or future (“condition”), to pay directly to, and exclusively in the name of Bulverde Physical Therapy and Wellness Center (“BPT & WC” or “Office”) such sums as may be owing to BPT & WC for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office (“charges”). I further grant a contractual lien to BPT & WC with respect to my charges, applicable to all payers, however I understand that nothing in the Agreement shall be construed as an election by BPT & WC to claim protection under any statutory lien law. For the purposes of the proceeds relation to commercial health or group insurance, disability benefits, workers compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and under insured motorist coverage, third party liability distributions, malpractice proceeds, attorney retainer agreement, and any other benefits or proceeds payable to me for the purposes stated herein.

I further agree that, in the event a payer refused to pay BPT & WC, I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to BPT & WC, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office’s name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letters of protection cannot be revoked or modified without the expressed written consent of the office. I further direct (and the office hereby requests) each attorney to provide immediate notice to the Office regarding funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and the provide a full accounting of such funds to the Office upon its request.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of the Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize BPT & WC to endorse/sign my name on any and all checks listing me as a payee which are represented to this Office for payment of any account relating to me, my spouse, or any of my dependents. I further authorize BPT & WC to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents.

I understand that I remain personally responsible for the total amounts due to BPT & WC for their services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse BPT & WC for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of BPT & WC and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interest of BPT & WC and myself. However, should any provision of this agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any part hereto, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect.

Patient Name: _____

Patient Signature: _____ Date: ____/____/____