REAL

PHYSICAL THERAPY

Patient Information			
Last Name	First Name	Middle Name	
Address	City	State	Zip
Home Phone	Cell Phone:	Work Phone	
DOB	Sex (M / F)	Marital Status	Social Security #
Email			
Emergency Contact		Phone #	
Is this a work related injury? _____yes _____no			
Prior to your evaluation today, have you had any Acupuncture, Physical, Occupational, or Speech Therapy this year? _____yes _____no			

Medicare Patients
Are you currently enrolled in Home Health? _____yes _____no

Referral Source	
I was referred to REAL Physical Therapy by:	
Physician Name:	Primary Care Physician:

I authorize Real Physical Therapy to release any medical information about me to the insurance company named above and its agents for the purpose of determining benefits or the payment of benefits. I also request that payment of benefits be made on my behalf directly to Real Physical Therapy. I understand that i am financially responsible for all services provided by Real Physical Therapy that are not covered by my insurance carrier.

Signature: Date:

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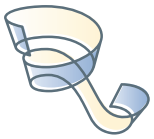
PHYSICAL THERAPY

Date

PRIMARY INSURANCE INFORMATION			
Insurance Company		ID	Group
Subscriber Last Name		First Name	Middle Initial
Employer Name			
Employer Address	City	State	Zip Code
Work Phone			Relationship to Patient
DOB	Sex (M / F)		Social Security

SECONDARY INSURANCE INFORMATION			
Insurance Company		ID	Group
Subscriber Last Name		First Name	Middle Initial
Employer Name			
Employer Address	City	State	Zip Code
Work Phone			Relationship to Patient
DOB	Sex (M / F)		Social Security

TERTIARY INSURANCE INFORMATION			
Insurance Company		ID	Group
Subscriber Last Name		First Name	Middle Initial
Employer Name			
Employer Address	City	State	Zip Code
Work Phone			Relationship to Patient
DOB	Sex (M / F)		Social Security



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Consent to Treat

_____ _____

Patient Name DOB

I authorize and consent to all Physical Therapy treatment and/or services provided by REAL Physical Therapy that are diagnosed, prescribed, deemed and considered necessary by the Physical Therapist(s) and/or the referring physician. I authorize Real Physical Therapy to release all information contained in my medical and financial records, including diagnosis and test results, to:

- Any doctor or health care specialist involved in my care
- My insurance company or health plan including Medicare
- Any person or entity responsible for paying or processing for payment of any portion of my healthcare bill(s)
- Governmental or accrediting agencies
- Any other healthcare provider to which I am referred or transferred for care
- Entities utilizing this information for quality management, peer review, and or outcome analysis
- 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 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.

I agree that if a company employee is exposed to my blood; I grant permission to REAL Physical Therapy 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.

_____ _____

Signature Date

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PHYSICAL THERAPY

FINANCIAL RESPONSIBILITY

Real Physical Therapy appreciates the confidence you have shown in choosing us to provide for you physical therapy needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. It is the policy of **REAL Physical Therapy** to file claims for you with your insurance company. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In addition, we will contact your insurance company to verify your physical therapy coverage. As always, we will strive to provide you with accurate and current information. However, we recommend that you contact your insurance company directly to be sure that you understand your benefits entirely and to be sure that your health insurance company gave us the correct information as well. It is not uncommon that the health insurance companies quote benefits incorrectly.

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that if I am participating in an HMO plan, my Primary Care Physician must authorize the services that I receive during my physical therapy care including todays and any future services rendered.

Your financial responsibility (co-pays, co-insurance, deductibles, etc.) is based on the benefits quoted by your insurance company before your claims are submitted. Therefore, you may owe additional money after your insurance company processes the claims. If insurance does not pay in a timely manner, the Guarantor must pay the remaining balance within 30 days from the time the insurance company notifies us of any services not covered. In the event that my insurance company forwards payment directly to me, instead of **REAL Physical Therapy**, I will immediately deliver such payment directly to **REAL Physical Therapy**. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. There will be a 1.5% late charge on any balance 90 days or over, once the insurance company pays.

NSF NOTICE

Initial _____

I understand that a $35.00 charge will be added to my account in the event our office receives a returned check. I understand that failure to pay as agreed above may result in this account being placed with an outside collection agency. I also understand that I will be responsible for any collection agency fees that may result from this action.

COLLECTION NOTICE

Initial _____

I understand that failure to pay as agreed above may result in this account being placed with an outside collection agency. I also understand that I will be responsible for any collection agency fees that may result from this action.

PERSONAL VALUABLES

Initial _____

I hereby release **Real Physical Therapy** and its associates of responsibility for loss or damage to personal property, including but not limited to clothing, money, or other valuables kept in my possession during my care.

ASSIGNMENT OF BENEFITS

Initial _____

I hereby authorized any and all insurance carriers, Medicare, attorneys, agencies, governmental departments, companies, individuals, and/or legal entities ("payers") to pay directly to **Real Physical Therapy,** benefits due me, if any, by reason of services described in statement rendered.

APPOINTMENT/CANCELLATION/NO SHOW POLICY

Initial _____

REAL Physical Therapy strives to achieve the goals that you, your physician, and your physical therapist has set for you to achieve through the prescribed therapy your physician felt was needed. This is an ongoing process that requires regular attendance to optimally beneficial. Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater than 15 minutes may result in a shortened treatment or cancellation. We respectfully request require 24-hours notice of any appointment cancellation. By giving us sufficient notice when cancelling an appointment, we can fill your scheduled time slot with someone else that needs our help. Failure to show for an appointment or cancellation without sufficient notice may be subject to a $25.00 charge. In addition, if you do not keep your appointments, your future appointments will be terminated after the second consecutive NO-SHOW and your physician will be notified

_____ _____

PATIENT SIGNATURE DATE

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PHYSICAL THERAPY

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed REAL Physical Therapy's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
NAME OF PATIENT OR REPRESENTATIVE DATE

_____
SIGNATURE

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE

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 Privacy Practices:

_____ _____
Patient Date

Reason (if given by patient):_____
_____
_____

_____ _____
Employee Signature Date

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PHYSICAL THERAPY

DATE

PAST MEDICAL HISTORY

NAME DOB

Current Injury/Issue:_____

Have you ever received treatment for this problem? Yes No

If so, what kind and where?_____

Please list any special tests performed for this problem (x-ray, MRI, labs, etc.):_____

_____

Have you ever had this problem before? Yes No
Treatment Received? Yes No
Using 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours:_____

The worst your pain has been during the past 24 hours:_____

Leisure activities, including exercise routines:_____

Occupation:_____

Are you on a work restriction? Yes No Do you smoke? Yes No
Do you have a pacemaker? Yes No Are you latex sensitive Yes No
Are you currently pregnant or think you may be pregnant? Yes No
Have you ever taken steroid medications for any medical conditions? Yes No
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Yes No

Allergies:_____

Current Medications:_____

_____

Have you recently noticed any of the following? (Check all that apply)	
Fatigue	
Weight loss/gain	
Muscle Weakness	
Difficulty Swallowing	
Shortness of Breath	
Headaches	
Bladder problems	
Fevers/chills/sweats	
Falls	
Dizziness/lightheadedness	
Constipation	
Fainting	
Difficulty with Balance	
Nausea/Vomiting	
Numbness or tingling	
Diarrhea	
Cough	

Have you ever been diagnosed with any of the following conditions? (Check all that apply)					
	YOU	FAMILY		YOU	FAMILY
Cancer			Diabetes		
Heart Problems			Osteoporosis		
Chest pain/angina			Multiple Sclerosis		
High blood pressure			Epilepsy		
Circulation problems			Kidney Problems		
Blood clots			Ulcers		
Stroke			Liver Problems		
Anemia			STD/HIV		
Alcoholism			Other:		
Depression					
Lung Problems					
Tuberculosis					
Asthma					
Rheumatoid Arthritis					
Hepatitis					
Eye Irritation/infection					
Thyroid Problems					

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Consent to Treat Minor / Verbal Consent Form

I, _____ the parent/legal guardian of _____ (DOB: _____), grant permission for my above named child to be treated at and by Real Physical Therapy. This consent covers the duration of his/her treatment plan. I hereby indemnify and hold harmless the Physical Therapists and other healthcare providers who act in reliance with this authorization.

Name of person who can make medical decision on parent's behalf:

_____

Date _____ Witness _____

Time _____ Second Witness _____

Additional Information:

Parent/Guardian can be located at the following phone number / address

Phone: _____

Address _____

_____

_____

Any Allergies and/or Medical Conditions of the child:

_____

_____

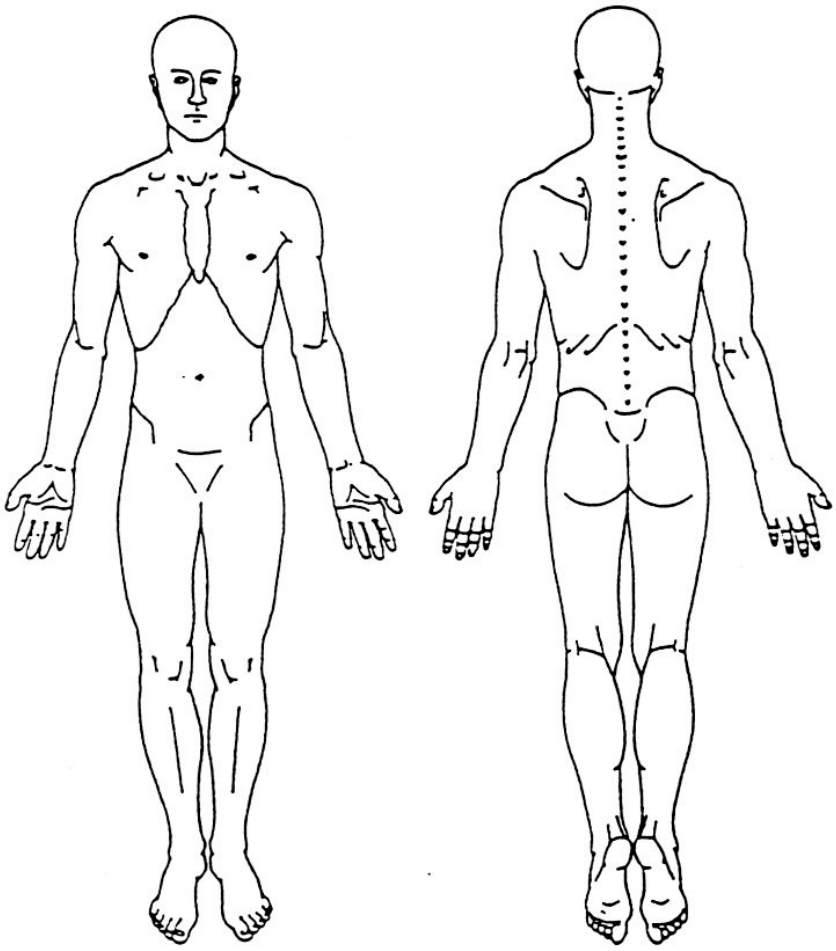
_____

Body Diagram

Instructions:

Please mark the areas where you feel symptoms on the chart below with the following symbols to describe your symptoms:

√ shooting/sharp pain
() dull/aching pain
III numbness
= tingling



My symptoms currently: □ come and go □ are constant □ are constant, but change w/activity

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NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result or the Health Insurance Portability and Accounting act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your Health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **REAL PHYSICAL THERAPY**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be closed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF YOUR INFORMATION

Appointment reminders. Your health information will be used by our staff to send appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- ⊙the right to request restrictions on the use and disclosure of your protected health information
- ⊙the right to receive confidential communications concerning you medical condition and treatment
- ⊙the right to inspect and copy your protected health information
- ⊙the right to amend or submit corrections to your protected health information
- ⊙the right to receive an accounting of how and to whom your protected health information has been disclosed
- ⊙the right to receive a printed copy of this notice

REAL PHYSICAL THERAPY'S DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices

We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the The Privacy Officer, REAL Physical Therapy, 4910 Golden Quail STE 140, San Antonio, TX 78240. Your request will be reviewed and will be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
REAL Physical Therapy
4910 Golden Quail STE 140
San Antonio, TX 78240

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
REAL Physical Therapy
4910 Golden Quail STE 140
San Antonio, TX 78240
210-561-8186

EFFECTIVE DATE

This notice is effective on or after January 2, 2011.