TRSMC
TEXOMA REHABILATION AND SPORTS MEDICINE CLINIC
3409 POST OAK CROSSING
SHERMAN, TEXAS 75092

Pat Deligans, PT, MEd
Phone 903-892-9590
Fax 903-893-4449

Patient's Name _____SS#_____
Mailing Address _____
City/State/Zip _____
Phone Numbers: Home _____Work _____ Cell_____
Date of Birth _____Marital Status: S M W D Email address: _____
Employer _____Occupation _____
If Minor, Parents/Guardian Name_____
Address _____
Street City State Zip Phone #
Referred by _____Follow up appointment date_____
Is this related to: **Motor Vehicle Accident**? _____**Job Injury (Worker's Comp)?**_____

INSURANCE INFORMATION

Primary Insurance_____
Name of Policy Holder_____
ID# _____Grp#_____
DOB (Policy Holder) _____Employer (Policy Holder)_____
Phone #_____

Secondary Insurance: _____
Name of Policy Holder _____
ID#_____Grp#_____
DOB (Policy Holder) _____Employer (Policy Holder) _____
Phone# _____

Worker's Comp _____
Adjuster _____Phone # _____
Claim# _____DOI:_____
Employer at time of injury _____Phone # _____

Auto Insurance_____ Phone #_____
Claim# _____ Date of accident_____

I hereby verify that all of the above information is true and correct.

Patient/Responsible Party Signature Date

MEDICAL INFORMATION

Have you had any Physical Therapy this year? _____
If so, where and for how long? _____
Have you had any Home Health Services this year?_____
If so, when _____Discharge Date _____
Agency Name_____

HAVE YOU HAD OR CURRENTLY DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

_____High/Low Blood Pressure	_____ Heart Condition	_____Pacemaker
_____History of Falls	_____Osteoporosis	_____Arthritis
_____Epilepsy/Seizures	_____Stroke	_____Mental Problems
_____Diabetes	_____Cancer	_____TB
_____Vertigo	_____Allergies_____	

Metal Implants, Where _____Sutures, Where_____
Other (Describe)_____
X-Rays-Date _____MRI-Date_____ CT-Date _____Injections-Date_____
Description of your symptoms/onset_____
_____

Any Recent Surgery or Accidents (Dates)_____
_____
How often do you experience your symptoms: constant ____ frequent____ intermittent ____
Describe the nature of your symptoms: sharp ____dull ache ____ numb ____ shooting ____
burning ____ tingling _____
How are your symptoms changing? Getting better ____No change _____Getting Worse____

Please list all medications, including prescription, over-the-counter, vitamins, etc.
_____
_____
_____
_____

Pain Level Today: No Pain- 0 1 2 3 4 5 6 7 8 9 10 - Worst

To the best of my knowledge, the above information is true and complete

Patient Signature_____Date_____

Parent's Signature, if minor _____Date_____

AUTHORIZATIONS, SCHEDULING AND PAYMENT POLICIES

Authorization for Treatment: I authorize Texoma Rehabilitation and Sports Medicine Clinic to perform all aspects of physical therapy treatment as prescribed by my attending physician. **(Initials) _____**

Authorization for Assignment of Benefits: I authorize any and all insurance payments to be paid directly to Texoma Rehabilitation and Sports Medicine Clinic for services rendered on my behalf. **(Initials) _____**

Authorization for Release of Medical Information: I authorize the release of any and all medical or other pertinent information that would be necessary for Texoma Rehabilitation and Sports Medicine Clinic to file any and all insurance claims. This would include any medical and/or other pertinent information pertaining to the attending physician or consulting physician or any hospital or clinic. I further authorize that any photocopy of this authorization is just as binding as the original. **(Initials) _____**

Scheduling: We ask that you be prompt in arriving for your scheduled appointments. We do our best to closely adhere to your appointment time and because we understand how valuable your time is as well. If you need to cancel an appointment, please call to reschedule. **Appointments must be cancelled at least 24 hours in advanced in order to avoid our $25.00 missed appointment fee.** Help us serve you and our other patients by keeping your schedule. You can call and leave a message on the recorder if needed. It is available 24 hours a day. **(Initials)_____**

Insurance Coverage: Your insurance coverage is a contract between you, and/or your employer and the insurance company. Our facility is a network provider for your health insurance plan, but we are NOT a party to your insurance contract, and therefore have no control over the provisions of your policy regarding deductibles, co-payments, or out of pocket cost. Therefore any questions regarding your coverage must be resolved by you with your insurance company. **(Initials)** _____

Payment: As a courtesy to our patients, prior to treatment our office staff will verify your benefits with your insurance carrier and then go over with you what your insurance company verified to our facility. However, please be advised that verification of benefits by your insurance company is NOT a guarantee of payment by your insurance carrier. Therefore, any amounts not paid by your insurance carrier such deductibles or co-payments will be your responsibility. Our facility accepts cash, credit, and debit cards, and checks for any amounts which are your responsibility. Checks returned by your bank will be subject to a $25.00 service charge. **(Initials)** _____

As the responsible party, you are signing that you have read and understand the Authorizations, Scheduling, and Payment Policies.

_____

Patient/Responsible Party Signature Date

TRSMC
TEXOMA REHABILITATION AND SPORTS MEDICINE CLINIC
3409 Post Oak Crossing
Sherman, Texas 75092

HIPPA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your right under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notated at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement the HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payments, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

__Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

__The practice reserves the right to change the privacy policy as allowed by law.

__The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

__The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

__The Practice may condition receipt of treatment upon execution of this consent.

May we phone or e-mail to you to confirm appointments? YES NO

Phone # _____ E-Mail _____

May we leave a message on your answering machine at home/cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

_____

This consent was signed by: _____

(**PRINT NAME PLEASE**)

Signature: _____ Date _____

Witness: _____ Date _____

TRSMC
TEXOMA REHABILITATION AND SPORTS MEDICINE CLINIC
3409 POST OAK CROSSING
SHERMAN, TEXAS 75092

TRSMC VERIFICATION OF INSURANCE BENEFITS POLICY

Our office will verify your insurance benefits with your insurance company and then notify you of the benefits which have been verified to our office by your insurance carrier. **However, please be advised regardless of what benefits have been verified by your insurance company, verification of benefits is NOT A GUARANTEE OF PAYMENT by your insurance carrier.**

Our facility is not a party to your insurance contract, and therefore has no control over your insurance policy's provisions such as deductibles, co-pays, or out of pocket costs. Once the "Explanation of Benefits" (EOB) is received from your insurance company, your benefits **could** be paid at a rate **different** than what was verified to our office resulting in either a portion of the bill being an additional "Patient Responsibility", or an overpayment to your account. If this occurs any additional "Patient Responsibility" will be billed to you once all the EOBs have been received from your insurance company, and any overpayment will be promptly refund to you once all the EOBs have been received.

I fully understand the above and am in agreement with TRSMC (Texoma Rehabilitation & Sports Medicine Clinic) policy regarding verification of insurance benefits. Furthermore I agree to pay any outstanding portion of my bill that is classified as "Patient Responsibility" by my insurance company.

PATIENT SIGNATURE DATE

WITNESS DATE