Paramount Physical Therapy & Rehab

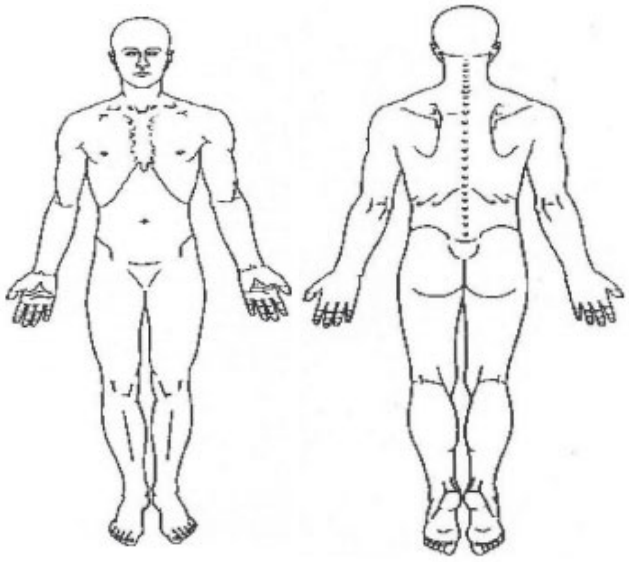
7575 San Felipe St., Suite 125, Houston, TX 77063
15925 Lexington Blvd., Suite B, Sugar Land, TX 77479
23531 Kingsland Blvd., Suite 300B, Katy, TX 77494
Ph# (713) 270-5900 Fx# (713) 270-5910

NAME:_____ DATE:_____
LAST FIRST MIDDLE

What is the main reason for your Physical Therapy visit today?

_____

Please use the diagram provided to mark where your symptoms are currently



When did this issue begin or when did you first notice symptoms?

_____

What do you think caused your current pain/problem?

_____

If issue is chronic, has there been a recent exacerbation of your pain? ☐ YES ☐NO
If yes, then when:_____

Is your injury due to a motor vehicle accident? ☐YES ☐NO
Is your injury work related? ☐YES ☐NO
What is your occupation?_____
Have you had any falls within the past year? ☐YES ☐NO

Have you had any prior treatment for this problem?
☐ Physical Therapy ☐Chiropractor ☐Massage ☐ Injections ☐Other_____

Have you had any diagnostic imaging performed for this problem?
☐X-ray ☐MRI ☐CT Scan ☐EMG ☐Ultrasound ☐Other_____

PAST MEDICAL HEALTH HISTORY (Mark all that apply)

☐ Cancer ☐ Diabetes I or II ☐ Stroke ☐ Seizures ☐ Depression ☐ Balance deficits ☐ Asthma
☐ High Blood Pressure ☐ Low Blood Pressure ☐ Heart Disease ☐ Thyroid ☐ Dizziness ☐ COPD
☐ Heart/Circulation problems ☐ Neurological problems ☐ Rheumatoid Arthritis ☐ Kidney Disease
☐ Incontinence ☐ Fibromyalgia ☐ Osteoporosis ☐ Osteoarthritis ☐ Digestive complications

Other conditions not reported_____

Are you wearing a Pacemaker, Defibrillator, or any other electrical device? YES☐ NO☐
*Females only: Are you currently pregnant? YES☐ NO☐

Surgical History

_____

_____

Please provide a list of your current medications (or feel free to attach a list)

_____

_____

_____

HOME ENVIRONMENT

☐Single story home ☐Two Story home ☐Apartment ☐Townhome Other:_____
Do you have any steps/stairs at home? ☐YES ☐NO

CURRENT COMPLAINTS/PAIN

Current pain level (0= no pain at all; 10=unbearable, worst possible pain)
0 1 2 3 4 5 6 7 8 9 10

TYPE OF PAIN	PAIN SYMPTOMS	IS YOUR CURRENT PAIN…
☐Dull	☐Constant (all the time)	☐Improving
☐Ache	☐Intermittent (relieved in some positions or rest)	☐Unchanged
☐Cramp	☐Occasional (daily or less frequent)	☐Worsening
☐Sharp	☐Infrequent (once a week or month)	
☐Burning	☐Variable (sometimes worse than others)	
☐Electrical		

Do you experience any numbness or tingling? ☐YES ☐NO
Do you experience any radiating pain? ☐YES ☐NO

What are 3 activities in your daily life that you have difficulty doing now due to your pain? (Examples include: bending, lifting, changing positions, reaching, walking, sitting, standing, cooking, etc)

1.

2.

3.

By signing below, I attest that the above information is correct and true to the best of my knowledge.

Patient: _____ **Date:** _____

Physical Therapist: _____ **Date:** _____

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PATIENT REGISTRATION

Name: _____ Date of Birth: _____
LAST FIRST MIDDLE INITIAL

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relationship: _____

EMPLOYER INFORMATION

Employer: _____

Employer Phone number: _____

INSURANCE INFORMATION

Primary Insurance:
_____
Insurance ID:
_____
Group #:
_____
Are you policy holder? YES☐ NO☐

Policy Holder Name:
_____
Policy Holder DOB:
_____
Patient relationship to policy holder:
Self ( ) Spouse ( ) Parent ( )

Secondary Insurance:
_____
Insurance ID:
_____
Group #:
_____
Are you policy holder? YES☐ NO☐

Policy Holder Name:
_____
Policy Holder DOB:
_____
Patient relationship to policy holder:
Self ( ) Spouse ( ) Parent ( )

I consent to rehabilitation and related services at: Paramount Health Services, LLC. I acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service, unless other arrangements are made with the financial department. Paramount Health Services, LLC will assist in billing my insurance company, but **I am ultimately responsible for payment should my insurance fail to pay within a reasonable period of time.**

Patient/Guardian Signature: _____ **Date:** _____

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ASSIGNMENT OF BENEFITS

- I assign to Paramount Health Services, LLC all benefits payable to me under my insurance policies and health benefit plans.
- I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims/billing and otherwise permitted or required in the Notice of Privacy Practices. Initials:_____

FINANCIAL RESPONSIBILITY

- If I participate in a health benefit plan, I acknowledge full financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment either because the plan deems such services not medically necessary or for any other reason.
- I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. Initials:_____

CONSENT TO TREATMENT

- I consent to rehabilitation and related services at: Paramount Health Services. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact and touch. Initials:_____

NOTICE OF PRIVACY PRACTICE

- I acknowledge receipt of Notice of Privacy Practice Initials:_____

LIABILITY

- I understand that Paramount Health Services, LLC is not responsible for items that are lost, stolen, or damaged while getting treatment. Initials:_____

Patient/Guardian Signature:_____ Date:_____

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ATTENDANCE POLICY

Welcome! We would like to take this opportunity to welcome you to Paramount Health Services, LLC and to thank you for choosing our organization for your physical rehabilitation.

- If unable to keep appointment, please notify the receptionist 24 hours prior to your scheduled appointment. Failure to attend an appointment will result in a $25.00 fee. You may reschedule any scheduled appointment time on the same date, subject to availability, without a penalty. Failure to attend 3 scheduled sessions, without prior notice, can result in release from our care with notification sent to you and your physician.

- Patients who are more than 15 minutes late may have to wait until the next available time slot. If you will be late or need to change your appointment, please contact the front desk immediately. Treatment time is limited to a maximum of 1 hour.

- Please refrain from asking any of the staff about the conditions of other patients being treated as it violates ethical and privacy standards.

- Appropriate attire for treatment: T-shirts, sweatshirts, shorts, sweatpants and tennis shoes are preferred. Refrain from wearing skirts or tight skinned clothing as it can limit proper examination and treatment.

- Another adult must accompany children under the age of 10 into the treatment area.

I have read and acknowledge the attendance policy at Paramount Health Services, LLC and agree to comply.

Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

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.

This practice is required by law to maintain the privacy of Protected Health Information (PHI), which is information about you, including demographic information, that may identify you and that relates to your past, present or future health and health care services. This Notice of Privacy Practices describes how we may use and disclose PHI. This practice reserves the right to amend this Notice.

(1) Uses and Disclosures of PHI: Your PHI may be used and disclosed by our practice that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law, such as: (a) Treatment: to provide, coordinate, or manage your health care and any related services, such as consultation, lab work, pharmacy, x-ray; (b) Payment: to obtain payment for health care services, such as claim filing or collection; and (c) Health care operations: to support the business activities of our practice, such as chart maintenance, regulatory requirements, accounting, federal compliance activities. This practice can elect to limit the uses or disclosure that it is permitted to make by law.

(2) Disclosures of PHI: This practice is permitted or required, under specific circumstances (such as when required by law), to use or disclose PHI without the individual's written authorization. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization in writing. This practice may contact the individual or other immediate adult family members to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.

PATIENT'S RIGHTS

You have the following rights: (a) to make informed decisions regarding your care; (b) to maintain confidentiality of information relating to you; (c) to receive care in a timely and competent manner as ordered by the physician in charge of your care; (d) to voice grievances and recommend changes without discrimination or reprisals; (e) to inspect and copy your PHI; (f) to request specific restrictions on certain uses and disclosures of PHI, such as requesting nondisclosure for the purposes of treatment, payment or healthcare, or to family members or friends; (g) the right to amend PHI; (h) to receive an accounting of disclosures of PHI; (i) to receive confidential communications of PHI by alternative means or at an alternative location; (j) to obtain a paper copy of the Notice from our practice upon request , even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may complain to us or to the Secretary of Health and Human Services, without retaliation, if you believe your privacy rights have been violated by us or if you think you were treated unfairly because of your sex, age, race, color, disability or national origin. You may submit a complaint in writing to Paramount Health Services LLC, 7575 San Felipe St., Ste. 125, Houston, TX 77063; OFFICE FOR CIVIL RIGHTS (OCR) @ (800) 368-1019 FAX (202) 619-3818, US DEPT OF HEALTH & HUMAN SERVICES, 1301 YOUNG ST., STE 106, Dallas, TX 75202