1ST Classen Physical Therapy

WITH YOU EVERY STEP OF THE WAY

633 E FERNHURST DR STE 803, KATY, TX 77450 | P:281-435-5732 | F:281-829-4567

NEW PATIENT PAPERWORK

Patient Name:
Date of Birth: Age: Gender:
Address:

I agree to allow you (1st Classen Physical Therapy) to text or voice message me for my appointment reminders to the number(s) listed below. By listing my mobile phone below, I understand that text or voice messages may NOT be secure, with a risk of unauthorized access to my information.
Mobile Phone: .

I agree to allow you (1st Classen Physical Therapy) to email my appointment information, related plan of care, exercise plans, and other therapy related information. By listing my email address below, I understand that email communications may NOT be secure, with a risk of unauthorized access to my information.
Email: .

Preferred Language: Need Interpreter:

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Unknown

Referring Physician: Phone: .
Primary Care Doctor: Phone:

Employment Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Disabled ☐ Retired ☐ None
Employer Name: Occupation:
Address: Phone:

Date of Injury/Surgery: Medical Problem:
Current Pain Rating: /10 How Low Pain Go: /10 How High Pain Go: /10
Functional Limitations:
Xray, MRI, Ct Scan Date & Results:
Have you received home health services in the last 2 months for any reason?

Have you gone to physical therapy or received any other kind of treatment for your issue in the last 2 months and/or currently?

Do you have home health for Nursing, PT or any other service?
→ Let the front desk know right away. You are not able to do outpatient physical therapy while doing home health services simultaneously. If you fail to let the front desk know you will receive a bill.

Is your injury related to MVA?
Date of MVA: Did you go to the hospital?:
Did you wear a seatbelt?: Did the airbags go off?
Xrays, MRI, imaging done?: MVA Claim # (INS):

Is your injury related to Workmen's Compensation ("WC")?
Date of Injury: Did you go to the hospital?:
Workmen's Compensation Case #:
WC Company Name: WC Contact:
WC Address: WC Phone:

Primary Insurance:
Policy Holder ("PH") Name: PH Date of Birth:
PH Phone:
Policy #: Group #:
PH Employer:

Secondary Insurance:
PH Name: PH Date of Birth:
PH Phone: Policy # Group #:

How did you hear about 1st Classen Physical Therapy?
Physician ☐ Specialist ☐ Hospital ☐ Case Manager ☐
Friend ☐ Former Patient ☐ Family ☐ Website ☐
Business Card ☐ Facebook ☐ Google Search ☐ Attorney ☐
School ☐ Other_____.

Medical Record Disclosure & Consent Forms

Patient Name: _____ Date of Birth: ___/___/___.

In case of emergency, please list who you would like us to contact below:

CONTACT 1#

Name: Relationship:

Phone: Work Phone:

Email:

CONTACT 2#

Name: Relationship:

Phone: Work Phone:

Email:

MEDICAL RECORD DISCLOSURE

I authorize the following individuals to have access to my medical and billing records:

Name: Relationship: Phone:

Name: Relationship: Phone:

PCP (if not referred by): Phone:

Specialist (if not referred by): Phone:

Attorney : Phone:

Patient Signature: _____ Date: _____.

Patient Consent Forms

Patient Name: _____ Date: ____/____/____.

1. CONSENT TO TREATMENT
    a. I consent to rehabilitation and related services at: 1st CLASSEN PHYSICAL THERAPY In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature.
    b. Patient Initials for Above: _____.

2. CONSENT TO TREATMENT OF MINOR
    a. I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
    b. Parent/Guardian Initials for Above: _____.

3. WAIVER & RELEASE
    a. I hereby release, discharge and acquit: 1st CLASSEN PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, injury, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care service.
        i. Patient Initials for Above: _____.

4. EXCULPATORY & INDEMNITY CLAUSE/LIABILITY
    a. In consideration for receiving permission to participate in any and all activities of physical therapy (by pcp, cardiologist, other speciality needed to clear my health prior to physical activity), which is sponsored by 1st Classen Physical Therapy, I hereby release, waive, covenant not to sue, and agree to hold harmless for any and all purposes sponsor, 1st Classen Physical Therapy, owners and their members, officers, agents, volunteers, or employees ("RELEASEES" or "INDEMNITEES") from any and all liabilities including personal valuables inside or outside the building, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in this activity or having therapist practice physical therapy medicine, also including traveling to and from the activity, or while on the premises owned, leased, or controlled by RELEASEE(S), including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEE(S). I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.
        i. Patient Initials for Above: _____.

5. PAYMENT AGREEMENT:
    a. I hereby assign all benefits directly to: 1st CLASSEN PHYSICAL THERAPY, 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 and otherwise permitted or required in the Notice Of Privacy Practices.
    b. I also agree to have a credit card on file for charges and any fees I may incur.
    c. Patient Initials for Above: _____.

6. FINANCIAL POLICY
    a. 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. To assist in establishing your account, please supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information. Once information is supplied you are agreeing that all information is correct and not falsified to the best of your understanding. Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered. Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.
    b. Patient Initials for Above: _____.

7. CANCELLATION POLICY AGREEMENT:
    a. I hereby understand that all appointments scheduled with 1st Classen Physical Therapy, are set up as to be completed and cannot be changed with less than 24 hours notice prior or I will receive an automatic fee and agree to have the clinic charge my card. This includes rescheduling same day appointments that do not allow the clinic to fill the spot with another patient. All sessions not kept by myself are subject to a **$50/cancellation fee**
    b. Patient Initials for Above: _____.

8. TRUE INFORMATION
    a. I certify that all of the information provided herein is true and correct.
    b. Patient Initials for Above: _____.
    c. Witness Signature: _____.
    d. Date: _____.

9. MARKETING RELEASE (OPTIONAL):
    a. Hereby consent to 1st Classen Physical Therapy allow and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("marketing materials") in

Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by the Clinic and will not be returned to me. I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization. Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

b. Patient Name: _____.
c. Date: _____.
d. Patient Signature: _____.
e. Legal Guardian Signature: _____.

10. HIPAA AUTHORIZED DISCLOSURE for PHI

a. I, the patient, hereby consent and authorize 1st Classen Physical Therapy (aka " 1CPT") and its employees, contractors, and affiliates (collectively "the clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") for the purposes of treatment, payment, and health care operations to other doctor's offices and insurance companies. All requirements for privacy and confidentiality set forth in HIPAA and other applicable law will apply to this office. 1CPT shall not use or disclose PHI except in accordance with applicable requirements of HIPAA. This policy shall apply to 1CPT acting as a covered health care provider under HIPAA. 1CPT will require a medical release & consent form must be signed for the clinic to share PHI with anyone not the patient or in the clinic (stated above). 1CPT is protected with HIPAA compliant security regarding email, phone, and EMR. Any breach of such information is in violation of security in place to protect PHI and those at fault will be prosecuted to full extent, and patient(s) will not hold 1CPT legally at fault for information obtained as protection was in place.

b. Patient Name: _____ Date: _____.
c. Patient Signature: _____.
d. Legal Guardian Signature: _____.

11. NOTICE PRIVACY/PATIENT BILL OF RIGHTS - HIPAA POLICY GIVEN AT REQUEST

a. I acknowledge receipt of Notice of Privacy Practices. Patient Initials: _____.
b. I acknowledge receipt of the Statement of Patient Rights. Patient Initials: _____.

COVID-19 Signs & Symptoms Screening

12. COVID 19 Screening
    a. For the safety of myself, 1st Classen Physical Therapy staff & employees, and other patients seen at 1st Classen Physical Therapy/Westside Medical clinic, I agree to answer all of the following truthfully and will not attend any session for therapy if I have any COVID 19 symptoms or test positive.
        i. ALERT: If asked to don a mask, please do so as some patients have autoimmunes, CA, pregnancy, etc and do require people in the clinic to mark. Otherwise we no longer use masks in the office.
            1. I have read and agree to 12.i.
                a. Initials:_____.
                    i. Please be aware that if you do not agree, we may reserve the right to reschedule your appointment.
        ii. ALERT: if exposed or positive to COVID 19 you agree to abide by the CDC regulations to prevent spread of the virus by quarantining for 5 days and returning to the clinic with a negative test.
            1. I have read and agree to 12.ii.
                a. Initials:_____.
                    i. Please be aware that if you do not agree, we may reserve the right to reschedule your appointment.
        iii. Have you received the COVID-19 Vaccine or tested positive for COVID-19 in the past year?
            1. Yes ☐
                a. When:_____.
            2. No ☐
        iv. I understand, if I do not feel well or have symptoms of Cold/Allergies/Covid, I may be asked to come back another day or to don a mask.

    b. Patient Signature:_____ Date:_____.