RIATA THERAPY SPECIALISTS
Physical Therapy • Sports Medicine • Wellness
www.riatatherapy.com

Patient Name: _____ DOB:_____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

Address:_____

Apt: _____ City:_____ State:_____ Zip:_____ Social Security No: _____-_____ -_____

E-Mail Address (Home): _____

Sex: M F Marital Status: S M D W Student: No FT PT Employment: FT PT Retired Unemployed

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Physician: _____ Next Scheduled appt. w/ referring Physician:_____

Employer: _____ Occupation: _____ Work Phone: _____

Date of onset/injury: _____ How did accident/injury occur? _____

_____

Have you had any Physical Therapy this year? _____ How many visits?_____

Are you currently being seen by a home health agency? Who? _____

_____

INSURANCE COVERAGE

Primary Insurance Carrier: _____ Member ID #: _____

Secondary Insurance Carrier: _____ Member ID #: _____

Tertiary Insurance Carrier: _____ Member ID #: _____

Cancellations and No-Shows: We take this subject seriously, because it can make the difference between whether you succeed in your treatment or not. Showing up for these visits is very important in achieving your goals in therapy. We require 24 hours notice of a cancellation. There will be a $25.00 charge for a cancellation or no show without proper notice. This charge will not be covered by your insurance plan and is your responsibility. Worker's Compensation and PIP patients; documentation has to be made of any missed appointments and forwarded to your case manager and primary care physician.

Patient Signature: _____ Date: _____

(If the patient is a minor, please have the parent sign here.)

Benefit Release Information: I authorize **Riata Therapy Specialists, PLLC** to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to **Riata Therapy Specialists, PLLC.** I also authorize the release of all clinical information to my referring physician and primary care physician so that he or she can be updated on my condition and the care I receive here.

Patient Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Authorization of treatment: I authorize **Riata Therapy Specialists, PLLC** to provide therapy services to myself or to _____ (my legal dependent). I understand I have the right to refuse therapy services at any time. I further understand no guarantees have been made by any representative of **Riata Therapy Specialists, PLLC** as to the outcome of this therapy.

Patient Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

HIPAA Privacy Practices Acknowledgement: I have received the notice of privacy practices and/or I have been provided an opportunity to review it. (This information is posted on the wall in the reception area, if you would like a copy to take with you please ask the front desk.)

Patient Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Auto & Personal Injury: I understand that involvement in an AUTO or PERSONAL INJURY ACCIDENT where a third party is partially or fully responsible for payment of any of my claims requires me to contact my medical insurance and set up a subrogation. I also understand that if I have failed to do this prior to my first visit I could be financially responsible for my entire balance due to insurance denial.

Patient Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Nondiscrimination Statement: Riata Therapy Specialists, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PATIENT'S REPRESENTATIVE AUTHORIZATION

In accordance with new federal regulations we are not allowed to discuss or even acknowledge that you are a patient of Riata Therapy Specialists without your expressed written consent. If there is anyone (i.e... spouse, parent, neighbor, etc.) you think might ever have a need to discuss your medical condition, your therapy, your appointment, or your financial account please list them below. This will prevent us from having to get your written consent each time they call to handle matters on your behalf.

1) Personal Representative's Name: _____
   Relationship to patient: _____ Phone #_____
2) Additional Representative's Name: _____
   Relationship to patient: _____ Phone #_____

I understand that I may revoke this authorization at any time by giving written notice to the front desk staff. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

Patient's Signature _____ Date _____

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PATIENT HEALTH HISTORY

Patient Name: _____ Primary Care Physician: _____

Please check if you have ever been treated for any of the following health conditions and the date when it occurred (or date diagnosed):

	Date(s)		Date(s)
_____ Anemia	_____	_____ Fractures:	_____
_____ Cancer	_____	_____ High Blood Pressure/Cholesterol	_____
_____ Heart Disease	_____	_____ Kidney disease	_____
_____ Liver Disease	_____	_____ Stroke	_____
_____ Heart Attack	_____	_____ Depression	_____
_____ Ulcers	_____	_____ Allergies	_____
_____ Migraines	_____	_____ Polio	_____
_____ Asthma	_____	_____ Car Accident	_____
_____ Other lung disease	_____	_____ Pregnancy	_____
_____ Pacemaker	_____	_____ Osteopenia or Osteoporosis	_____
_____ Other	_____		

Please list any past surgeries with dates: _____

_____

Please list your date of injury (if applicable) or duration of current symptoms: _____

_____

Please list any medications you are currently taking: _____

_____

Do you smoke or use chewing tobacco?:

_____

Please describe your pain (throbbing, sharp, dull, ache, constant, intermittent, etc.): _____

_____

What is your desired outcome from physical therapy?: _____

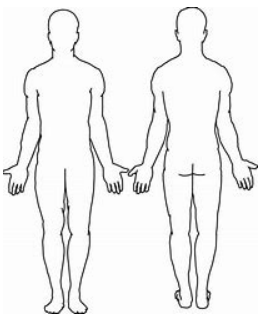
_____

Over the last 2 weeks, how often have you been bothered by the following problems? (Circle or X one)

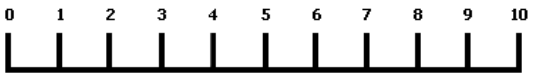
1. Little interest of pleasure in doing things ☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day

2. Feeling down, depressed or hopeless ☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day

Please indicate your location of pain on the diagram below:



Please indicate where your pain level is on the line below (0 = none, 10 = emergency room pain):



Patient Height: _____
Patient Weight: _____