Dallas Midtown
Physical Therapy
& Rehabilitation

Patient Registration

Personal Information ***Please complete all areas.***

Social Security Number: _____ Date of Birth: _____ Driver's License #_____

Last Name: _____ First Name: _____ MI: ___

Address: _____ City, State, Zip: _____

Email Address: _____ Sex: ___ Male ___ Female (check one = X)

Home Phone: _____ Work Phone: _____ Cell / Pager #: _____

Marital Status: ___ Single ___ Married___ Other: _____ (check one = X)

Insured Party / Responsible Party (Leave Blank if same as patient)

Social Security Number: _____ Date of Birth: _____

Last Name: _____ First Name: _____ MI: ___

Address: _____ Relationship to Patient: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell / Pager #: _____

Sex: ___ Male ___ Female (check one = X) Marital Status: ___ Single ___ Married ___ Other: _____

Patient's Employer Information: Name: _____
Address: _____ City: _____ State: ___ Zip: _____

Insured's Employer Information: **(Leave Blank if same as patient)** Name: _____
Address: _____ City: _____ State: ___ Zip: _____

Emergency Contact Information: Name: _____ Relationship: _____

Home	Work	Cell / Pager
Phone: _____	Phone: _____	Phone: _____

Other Information:
Date of Injury: _____

Type of Accident: __ No Accident __ Auto __ Work __ Other

If Auto Accident, list State where accident occurred: ____

Description of Injury: _____

*** NOTICE: If you are a Medicare patient, ARE YOU RECEIVING HOME HEALTH? ___ YES ___ NO**

Patient Certification and Signature: I certify that all of the information provided herein is true and correct.

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

Email Policy: Dallas Midtown Physical Therapy may send emails with non-sensitive information and will not share your contact information with anyone. Would you like to receive appointment reminders as well as newsletters from Dallas Midtown Physical Therapy and Rehabilitation? ___Yes ___No

4101 McEwen Drive | Suite 100 | Dallas, Texas 75244
Ph: 972.701.0366 | Fax 972.701.0372

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MEDICAL HISTORY

Patient Name _____

Reason for therapy or testing

_____

Date and description of injury _____

Diagnostic tests and results

_____

_____

Previous treatment received (what, when, where ?)

Physical Therapy _____

Surgery _____

Other _____

Check any and all conditions listed below that you now have or ever had.

__ High blood pressure	__ Migraine headaches	__ Arthritis
__ Diabetes	__ Heart disease	__ Pacemaker
__ Vascular disease	__ Open wounds	__ Current infections
__ Current flu or fever	__ Hernia	__ Current pregnancy
__ Osteoporosis	__ CVA / stroke	__ Seizures
__ Cancer	__ Fractures	__ Depression

Date and details of any conditions listed above, or about conditions not listed:

_____

_____

_____

List any medications that you are taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Who is your Primary Care Physician?

Name _____ Phone # _____

Patient / Parent / Guardian signature _____ Date _____

Therapist's initials after review of information _____ Date _____

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Patient Authorization

Patient Name: _____

Release of Information

All information provided herein is true and correct. I hereby consent to treatment.

I give permission to Dallas Midtown Physical Therapy & Rehabilitation to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize Dallas Midtown Physical Therapy and Rehabilitation to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. Information without patient identifiers may be used for quality assurance purposes. I have read and understand the above release.

Patient or Guardian Signature: Date:

Assignment of Benefits

I authorize payment directly to Dallas Midtown Physical Therapy & Rehabilitation for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient or Guardian Signature: Date:

Notice of Privacy Practices (HIPAA Acknowledgement / Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices from Dallas Midtown Physical Therapy & Rehabilitation. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Patient or Guardian Signature: Date:

Payment Guarantee

I agree to pay Dallas Midtown Physical Therapy & Rehabilitation for the services provided to me or the party named above. If any law, such as Workers' Compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate and the insurance company changes its coverage, I will be responsible for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Dallas Midtown Physical Therapy & Rehabilitation.

Patient or Guardian Signature: Date:

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