



For Your First Appointment...

1. Bring a photo ID
2. Bring all current insurance cards
3. Bring referral from your physician for physical therapy
4. Bring current list of medications or fill out our list on last page (preferred)
5. Please wear comfortable clothing
6. Please check in at the front desk when you arrive
7. Please tell us before you follow up with your doctor so the most current treatment notes can be sent prior to your appointment



Patient information form

Patient Information Name (Last, First, MI) _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell Phone _____

Email _____

Employer Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Problem/Major Complaint _____ When did it start _____

Motor Vehicle Accident Yes___ No___ Date of Accident _____ State of Accident _____

Work Place Injury Yes___ No___ Date of Injury _____

Open work comp claim Yes___ No___ Claim # _____

Referring Physician Name _____ Phone _____

Primary Care Physician Name _____ Phone _____

Primary Insurance _____ ID _____

Secondary Insurance _____ ID _____

Subscriber Name _____ Date of Birth _____

Tertiary Insurance _____ ID _____

Subscriber Name _____ Date of Birth _____

Disputes regarding benefits are between the patient and the insurance company. Notification of changes to insurance is the responsibility of the patient. All charges are ultimately the responsibility of the patient. My representative or I, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and/or physical therapist.



Thank you for choosing Lambeth Physical Therapy as your outpatient physical therapy provider. In order for you to fully benefit from our services, we would like you to become familiar with our philosophy and treatment approach. Take special note that we believe in a team approach to care. Our team involves the referring physician, us and you.

Philosophy of Care

Our goal is to fully assess you and your condition through hands on research based approach. We will discuss our findings with you and together we will develop a comprehensive treatment strategy that will meet your goals. We provide compassionate yet effective treatment. Another goal is to empower you with a full knowledge and understanding of your condition. We believe in a free exchange of ideas and value your questions and thoughts. We make an effort to create a relaxed, customer oriented, and fun environment. Each day is a fantastic, fulfilled and feel good therapy day!

Appointments and Attendance

Please arrive on time for your appointments. If you are more than 15 minutes late, your appointment may have to be rescheduled depending on your therapists' schedule. Please be mindful that arriving late does not only affect your therapy but the therapy session of the person scheduled after you. For treatment to be effective and covered by insurance, it is important for you to be treated consistently. If you are unable to attend an appointment, please call us at least 24 hours in advance to reschedule. This will allow us to give your appointment to another patient. There will be a \$25.00 service charge for any No Show appointment, or if cancellation occurs with less than 24 hour notice. Missing more than 2 scheduled appointments without advance notice may result in scheduling your appointments on a day-to-day basis or cancellation of future scheduled appointments. In order to fully benefit from therapy, it is important to attend therapy sessions consistently and perform your home program as prescribed by your therapist. If you feel that therapy is not meeting your needs, please bring it to our attention immediately. We will be happy to modify your program to ensure a successful recovery.

Follow-up visits with your physician

We periodically assess your progress and send reports to your physician. Please advise us of all upcoming appointments with your physician.

Insurance

As a courtesy, by the end of your initial visit, our front office staff will contact your insurance company to verify therapy eligibility and benefits. You are responsible for paying deductible and co-pays/co-insurances at the time of your visits. If you have accrued a balance of over \$100.00, some form of payment is due at the time of service. If you are having difficulty with this payment, please talk with the Office Manager regarding this matter before you decide to cancel appointments. Unpaid balances over 60 days will be charged a \$15.00 late fee. Returned checks will be subject to \$30.00 collection charge.

Authorization to Release and Assign Insurance Benefits:

I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Lambeth Physical Therapy the medical benefits I am entitled from my insurance company and/or Medicare. I hereby acknowledge and agree to the Financial Policy above. I will adhere to the cancellation and no show policy.

Patient's Signature * (Or Authorized Signature)

Date *

Printed Name of Patient

Relationship to patient



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.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of the medical practice for Lambeth Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information Appointment reminders: Your health information will be used by our staff to send you appointment reminders. **Information about treatments:** Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information



- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Lambeth Physical Therapy Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Lambeth Physical Therapy PLLC

1121 S Magnolia St. Suite 800

Woodville, Texas 75979

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name of the person you can contact for further information concerning our privacy practices is:

Company Owner: Matt Lambeth

I have received or been offered and declined a copy of Lambeth Physical Therapy's Privacy Practices. I have had the opportunity to have any questions answered regarding the privacy practices of the clinic.

Patient's Signature * (Or Authorized Signature)

Date *

Printed Name of Patient

Relationship to patient if not patient



Emergency Contact Information

I, _____, give my permission to Lambeth Physical Therapy to release the following information to the individuals listed below. Even if you choose to leave this form blank, please sign and date at the bottom.

- Date and Time of appointments
- Account information
- Insurance information
- Medical records

1) Name _____ Relationship to patient _____

Phone Number _____

2) Name _____ Relationship to patient _____

Phone Number _____

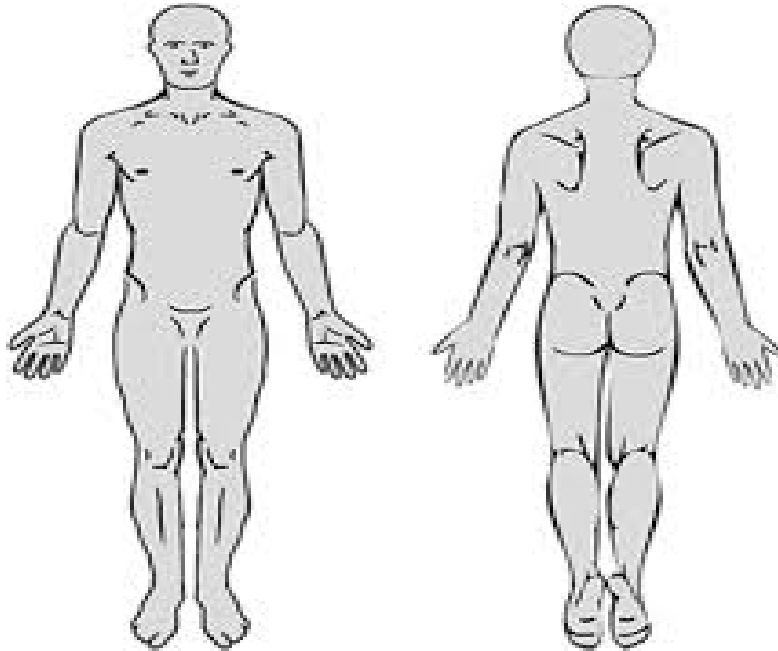
3) Name _____ Relationship to patient _____

Phone Number _____

Signature _____ Date _____

Updated _____ Date _____

Updated _____ Date _____



YOUR PAIN: (Please indicate your level of pain by circling a number from 0 to 10)

0-10:No Pain 1-3/10:Minimal Pain 4-6/10: Moderate Pain 7-9/10: Severe Pain 10/10: Need ER Now

My current pain is 0 1 2 3 4 5 6 7 8 9 10

Best pain has been in last week 0 1 2 3 4 5 6 7 8 9 10

Worst pain has been in last week 0 1 2 3 4 5 6 7 8 9 10

Are there times when you are pain free Yes No

What percent of the day are you pain free % of the day

My symptoms are Getting better Getting worse Not changing

What activities are limited or what makes your symptoms worse_____

What activities/movements help or relieve your symptoms_____

At this time, would you say your health is Excellent Good Fair Poor



Briefly describe your symptoms _____

Do you have any numbness/tingling Yes No If Yes, Where _____

Date your symptoms began _____

Date of surgery (if applicable) _____

What caused your symptoms to begin _____

Symptoms worsen (circle whichever applies)

Morning Evening Night With activity Without activity

Which type of diagnostic testing have you had? (circle all that apply)

X-Rays MRI CT scan EMG

Nerve conduction testing Bone Scan Blood testing

Date performed _____ Facility/Provider performed _____

Results if known _____

Most important question: What are your goals for physical therapy?

Have you ever had these symptoms before Yes No Date(s) _____

Please circle any other forms of treatment you have had for this condition

Injections Surgery Chiropractic Physical therapy Other

Have you fallen within the last year? Yes No

If Yes, How many times Yes No Were you injured when you fell? Yes No

Work Requirements (if applicable)

How much do you lift in a day? 0-10 lbs 10-20 lbs 20-50 lbs >50 lbs How much _____

How much do you sit in a day? 1-3/day 2-3/day All day

Are you restricted from work at this time? Yes No



Please indicate specific work tasks that increase your symptoms_____

For a thorough and complete evaluation, please provide us with this important background information. If you do not understand a question please ask your therapist.

List any allergies to medications or other allergies you have_____

Please circle any of the following whose care you are under:

Medical doctor	Pain Physician	Surgeon	Osteopath	Chiropractor
Neurologist	Psychiatrist/Psychologist		Physical Therapist	Other_____

Tobacco use: Do you smoke Yes No

Have you EVER been diagnosed with the following conditions? If no leave field blank

Cancer If YES, what kind?	Asthma
High Blood Pressure	Anxiety
Heart Problems If YES, what kind?	Arthritis
Hepatitis	Rheumatoid Arthritis
Kidney Disease If YES, what kind?	High Cholesterol
Circulation Problems	Stroke
Tuberculosis	Diabetes
Blood Clots or Difficulty Clotting	Multiple Sclerosis
Chemical Dependency (i.e. alcoholism, drugs)	Lyme Disease
Thyroid Problems Hypo or Hyper?	Depression
Stomach Ulcers	

Please list any significant injuries (fractures, dislocations, etc.) or surgeries and their approximate date_____



Medication Verification Form

Patient Name: _____ DOB: _____

Current Medications including over-the-counter medicines and supplements:

Medication	Dosage	Frequency

Patient Signature _____ Date _____