



# New Patient Information

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Email Address: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employers Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact Outside the Home: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Onset Date (injury, accident, surgery date or recent date symptoms started): \_\_\_\_\_

**MEDICARE PATIENTS: Are you currently enrolled in Home Health?** Check one  Yes  No

*If Yes: (List Company Name)* \_\_\_\_\_

## WORKERS COMPENSATION / AUTO ACCIDENT

If you want us to bill for Workers Comp or an auto accident, we will do so. We ask that you present us with your private health insurance information as backup. I do not wish to provide a copy of my private health insurance card. I realize that if my workers comp or auto benefits should be denied or exhausted that I would be responsible for any charges incurred.

Please sign: \_\_\_\_\_ Date: \_\_\_\_\_

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Please visit our website. [www.TexPTS.com](http://www.TexPTS.com)



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## CONSENT TO THERAPY

1. I have presented myself to this facility for therapy treatments and consent to diagnostic procedures and care provided by my attending therapist.
2. I realize I have the right to refuse any drugs, treatments or procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.
3. I understand that if I do not attend therapy for two weeks or miss three consecutive appointments that I am subject to discharge. Once I have been discharged, I understand that I will need a new physician's order/referral for any further therapy and will be receiving a new evaluation. This is in compliance with the Texas State Law.
4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and **FULLY UNDERSTAND the PATIENT FINANCIAL RESPONSIBILITIES FORM.**
5. WORKERS COMPENSATION - I hereby authorize my rehab consultant to receive my records related to my work injury.
6. This facility takes photographs of patients while performing therapy to be displayed on the facility bulletin board. Do you consent to have your photograph taken? *Check one* Yes No

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

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Signature of Patient (or Parent if Patient is a Minor –under 18)

Date

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Witness (Authorized Signature of TexPTS Employee)

Date