

The logo features a blue circular graphic with a white ring inside, resembling a stylized 'S' or a path. The words 'S A N A N T O N I O' are spaced out across the top of the ring. Below the ring, the text 'Center for Physical Therapy' is written in a bold, black, sans-serif font.

S A N A N T O N I O  
**Center for Physical Therapy**

Dear Patient,

Thank you for choosing San Antonio Center for Physical Therapy for your rehabilitation needs. We want your time with us to be a positive experience, one that leads you down a road of successful healing and healthy living. Feel comfortable in knowing that you will be treated every session by one of the few practitioners in San Antonio that is both a Doctor of Physical Therapy and a Certified Manual Therapist.

On your first visit with us, your Doctor of Physical Therapy will perform a comprehensive evaluation based on the prescription that was given to you by your Physician. Following your evaluation, your Doctor will create a personally tailored pain relief program for you. In most cases, treatment will begin the same day as your evaluation.

Please come to each session wearing comfortable attire that allows sufficient mobility and accessibility to the injured region. We welcome questions, comments and concerns, and we are eager to help you understand your ailment.

Please fill out the new patient paperwork and bring it with you, along with a photo ID and health insurance or Medicare card.

Again, thank you for choosing San Antonio Center for Physical Therapy. Happy healing.

Respectfully,

San Antonio Center for Physical Therapy



**PAST MEDICAL HISTORY**

Do you currently have or have you ever been diagnosed with any of the following:

	Yes	No		Yes	No
Arthritis			High Blood Pressure		
Asthma/Chronic Bronchitis			HIV/AIDS		
Bowel/Bladder Problems			Osteoporosis		
Cancer			Rheumatoid Arthritis		
Chest Pain			Stroke		
Diabetes			Alcoholism		
Emphysema			Drug Abuse		
Epilepsy/Seizures			Are you currently pregnant?		
Heart Disease/Attack			Do you have a pacemaker?		
Hepatitis			Do you have surgical implants?		

Do you currently have any current or past health or medical problems that are not listed above?

If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_

Please list all surgeries and the approximate date of the operation: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all medications that you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex: M / F  
Marital Status: \_\_\_\_\_ Email: \_\_\_\_\_

**POLICY HOLDER'S INSURANCE INFORMATION:**

Insurance Company's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex: M / F  
Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

Insurance Company's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PATIENT EMPLOYMENT INFORMATION:**

Employer's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Full Time / Part Time / Retired

**REFERRING PHYSICIAN INFORMATION:**

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**ADDITIONAL INFORMATION:**

Is this a work related injury? Yes / No. If yes, what was the date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this an auto related injury? Yes / No. If yes, what was the date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Attorney's Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Case Manager's Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Have you received Physical Therapy for any condition this year? Yes / No. # of visits: \_\_\_\_\_

How did you hear about us? Physician / Friend / Mail / Yellow Pages / Returning Patient / Other



## INSURANCE & SCHEDULING INFORMATION

In consideration of services rendered, I hereby transfer and assign all right to payment due to me for physical therapy services under any policies of insurance to San Antonio Center for Physical Therapy (SACPT). As a courtesy, SACPT will contact my insurance carrier for verification of my physical therapy benefits and will make every effort to discuss those benefits with the patient/responsible party in a timely manner. **However, I understand that I am responsible for contacting my insurance carrier for determination of my physical therapy benefits and that I am responsible for payment of any services applied towards my co-payment, coinsurance, deductible and/or services not deemed medically necessary by my insurance carrier.**

**Regarding Appointments:** Keeping your appointments is very important to the success of your therapy. If you are unable to keep an appointment, we ask that you please contact our office 24 hours in advance. If you do not call 24 hours in advance, you may be subjected to a \$25 cancellation fee. In addition, after three (3) “no shows”, your doctor will be informed and your name will be removed from the schedule.

**Regarding Children:** For the safety of our patients and your children, unattended small children are prohibited in the fitness room and/or the reception area.

**Returned Check Fee & Collection Fee:** There will be a \$30 charge for any check returned for insufficient funds. In addition, in the event of default, for any reason, the patient will be responsible for any and all fees associated with the collection process.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



## **Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed San Antonio Center for Physical Therapy's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Patient / Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



## **Acknowledgement of Review of HIPAA Privacy Rules**

I have been given the opportunity to review the HIPAA Privacy Rules, which explains a set of national standards for the protection of certain health information.

\_\_\_\_\_  
Patient / Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
SAN ANTONIO CENTER FOR PHYSICAL THERAPY, \_\_\_\_\_

P.C.

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