

# VICTORIA PHYSICAL THERAPY, P.C.

3412 SAM HOUSTON DRIVE  
VICTORIA, TX 77904

Phone: (361) 578-3513  
Fax: (361) 578-4623

Referring Doctor: \_\_\_\_\_

Account #: \_\_\_\_\_

\*\*\*\*\*Are you currently receiving Home Health? Yes ☐ No ☐

IF YES, STOP HERE!!!\*\*\*\*\*

Have you had previous therapy for your injury? Yes ☐ No ☐

Date of Therapy: \_\_\_\_\_

Is the reason for today's visit work related? Yes ☐ No ☐

Date of Accident: \_\_\_\_\_

Is the reason for today's visit due to an automobile accident? Yes ☐ No ☐

Attorney Name: \_\_\_\_\_

Attorney Phone #: \_\_\_\_\_

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

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

DL #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell/Alternate Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

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

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

Work Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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

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

Work Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

In case of an emergency, please notify: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

If patient is under 18, please list name of parent or guardian: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Name of Person Insured: \_\_\_\_\_

DOB: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Relationship to Patient: Self

Spouse

Dependent (Child)

Secondary Insurance: \_\_\_\_\_

Name of Person Insured: \_\_\_\_\_

DOB: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Relationship to Patient: Self

Spouse

Dependent (Child)

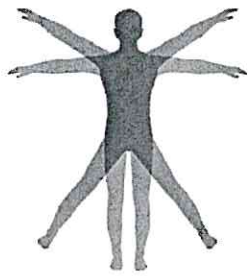
## AUTHORIZATION FOR CARE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I give my consent to receive physical/occupational therapy treatment to be performed by the staff of Victoria Physical Therapy, P.C. I assign all payments to be paid directly to Victoria Physical Therapy, P.C. for all services described on the attached claim or statement. I further hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I acknowledge and understand that I am responsible for all the charges for all the services rendered to me or any member of my family.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# VPT

VICTORIA PHYSICAL THERAPY, P.C.

## PATIENT INFORMATION CONSENT FORM

I have read and fully understand Victoria Physical Therapy, PC's Notice of Information Practices. I understand that Victoria Physical Therapy, PC may obtain or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have to restrict how my personal health information is used and disclosed for treatment, payment and administration operations, if I notify the practice. I also understand that Victoria Physical Therapy, PC will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Victoria Physical Therapy, PC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

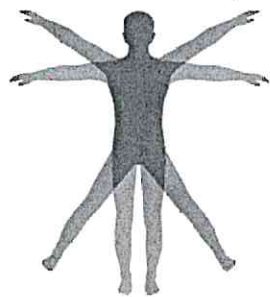
## MEDICAL RELEASE FORM

I, \_\_\_\_\_, give my permission to Victoria Physical Therapy, PC to obtain any and all medical records currently in your possession which are needed to assist in my care and treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Mary E. Drost PT, DPT, CEEAA  
Bryan McAdams PT, DPT, OCS, CSCS



# VPT

VICTORIA PHYSICAL THERAPY, P.C.

## DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient Name

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

\_\_\_\_\_  
Date

Mary E. Drost PT, DPT, CEEAA  
Bryan McAdams PT, DPT, OCS, CSCS

## NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

**Before you make a decision, you should read this entire notice carefully.** Ask us to explain, if you don't understand why Medicare won't pay. Ask us how much these items or services will cost you (**Estimated Cost: \$\_\_\_\_\_**).

**Medicare will not pay for:** Services beyond the Physical Therapy cap of \$2010.00 for the year 2018

☐ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion \* from Medicare benefits:**

- |   |  |
|---|--|
| <input type="checkbox"/> Personal comfort items.  | <input type="checkbox"/> Routine physicals and most tests for screening. |
| <input type="checkbox"/> Most shots (vaccinations).   | <input type="checkbox"/> Routine eye care, eyeglasses and examinations.  |
| <input type="checkbox"/> Hearing aids and hearing examinations.   | <input type="checkbox"/> Cosmetic surgery.                               |
| <input type="checkbox"/> Most outpatient prescription drugs.  | <input type="checkbox"/> Dental care and dentures (in most cases).       |
| <input type="checkbox"/> Orthopedic shoes and foot supports (orthotics).  | <input type="checkbox"/> Routine foot care and flat foot care.           |
| <input type="checkbox"/> Health care received outside of the USA.   | <input type="checkbox"/> Services by immediate relatives.                |
| <input type="checkbox"/> Services required as a result of war.  | <input type="checkbox"/> Services under a physician's private contract.  |
| <input type="checkbox"/> Services paid for by a governmental entity that is not Medicare.   |  |
| <input type="checkbox"/> Services for which the patient has no legal obligation to pay.   |  |
| <input type="checkbox"/> Home health services furnished under a plan of care, if the agency does not submit the claim.  |  |
| <input type="checkbox"/> Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.  |  |
| <input type="checkbox"/> Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).                  |  |
| <input type="checkbox"/> Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.            |  |
| <input type="checkbox"/> Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF. |  |
| <input type="checkbox"/> Services of an assistant at surgery without prior approval from the peer review organization.  |  |
| <input type="checkbox"/> Outpatient occupational and physical therapy services furnished incident to a physician's services.  |  |

**\* This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

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

\_\_\_\_\_  
Date

Victoria Physical Therapy, P.C.

Due to Medicare regulations, we need to advise you that certain rules determine if you can have out-patient physical therapy. Please initial below the services you are currently receiving:

- \_\_\_\_\_ Visits by a nurse for administering medicine, taking blood pressure or any nursing tasks.
- \_\_\_\_\_ Home Health Services- someone helps you with bathing, cooking, cleaning your home, etc.
- \_\_\_\_\_ Physical Therapy
- \_\_\_\_\_ Speech Therapy
- \_\_\_\_\_ Occupational Therapy- working with you on activities of daily living.
- \_\_\_\_\_ Medical Social Services
- \_\_\_\_\_ Supplying any routine or non-routine medical supply; ie: wheelchair, etc.

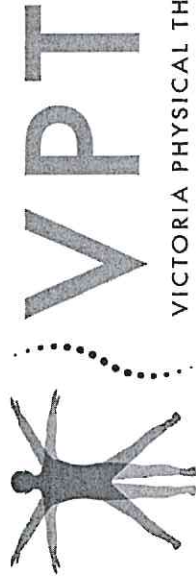
If you have checked any of the above, you are not eligible for Medicare to pay for your out-patient physical therapy. If you choose to come, you will be personally responsible for all expenses incurred. Payment will be required at the time of service.

If you begin out-patient physical therapy and then enter a Home Health service, you must notify us immediately so we can stop your services. If you continue, you will held responsible for services you receive that are not reimbursed by Medicare.

\*\*\*I fully understand the above statements and agree to be responsible for payment for all services I receive if I become ineligible due to Medicare regulations.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



VICTORIA PHYSICAL THERAPY, P.C.

## My Medicine Record

These are my medicines as of:

NAME:

BIRTH DATE:

	NAME	DOSE	FREQUENCY	DOCTOR	MEDICAL CONDITION
***Enter all prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements. ***					
EX	Crestor	25 mg	Take orally 2 times a day	Dr. John Smith	Lower cholesterol
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					





# MEDICAL SCREENING QUESTIONNAIRE

Date: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Gender: Male/Female

Age: \_\_\_\_\_

Smoker: Yes/No

Pregnant: Yes/No

Have you had any diagnostic imaging (X-Ray/MRI) or blood work for your current symptoms? Yes/No

Past Surgical History (include date):

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Explain your regular exercise routine:

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Do you take blood thinners? Yes/ No

Are you allergic to latex? Yes/ No Other allergies: \_\_\_\_\_

Does coughing, sneezing or taking a deep breath make your pain worse? Yes/ No

Do you have pain with bowel, bladder or sexually related activities/functions? Yes/ No

I am currently experiencing (check all that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Difficulty swallowing   | <input type="checkbox"/> Increased pain at night/rest | <input type="checkbox"/> Poor balance, falls or dizziness |
| <input type="checkbox"/> Numbness/tingling       | <input type="checkbox"/> Bowel/bladder changes        | <input type="checkbox"/> Pain with menstruation           |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Vision changes                   |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Changes in appetite          | <input type="checkbox"/> Pain with eating                 |
| <input type="checkbox"/> Nausea/vomiting         | <input type="checkbox"/> Headaches                    |   |

Where are you currently having symptoms? \_\_\_\_\_

Approximately what date did your present symptoms start? \_\_\_\_\_

How did your symptoms start? Gradual/sudden/injury \_\_\_\_\_

My symptoms are currently: Getting better/staying about the same/getting worse

Have you had these symptoms before? Yes/ No

Have you received other treatment for these symptoms? Yes/ No If yes, did you get better? Yes/ No

How do you sleep at night? Fine/moderate difficulty/only with medication

Do you have any learning barriers? Yes/ No If yes, list: \_\_\_\_\_

What are your personal goals for therapy? \_\_\_\_\_

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## MEDICAL SCREENING QUESTIONNAIRE

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes/No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes/No

Is this something with which you would like help? Yes, today/Yes, but not today/No help

On the scale below, please circle the number which best represents the severity of your pain:

**AVERAGE** for the past 48 hours:

No Pain    1    2    3    4    5    6    7    8    9    10    Worst Pain Imaginable

**BEST** for the past 48 hours:

No Pain    1    2    3    4    5    6    7    8    9    10    Worst Pain Imaginable

**WORST** for the past 48 hours:

No Pain    1    2    3    4    5    6    7    8    9    10    Worst Pain Imaginable

Activities which make your pain worse (check all that apply):

- |   |                                   |                                   |  |
|---|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Lying down     | <input type="checkbox"/> Bending  | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking           |
| <input type="checkbox"/> Turning in bed | <input type="checkbox"/> Stress   | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Reaching overhead |
| <input type="checkbox"/> Lifting        | <input type="checkbox"/> Twisting |                                   |  |

Any other activities that make your pain worse: \_\_\_\_\_

Are there any activities that make your pain better? Yes/No If yes, please list. \_\_\_\_\_

List the best and worst time of day for your pain. Best: \_\_\_\_\_

Worst: \_\_\_\_\_

On the scale below, circle the number which best represents your overall level of function:

Cannot do anything    1    2    3    4    5    6    7    8    9    10    Able to do everything

Use this space to explain and/or describe any other information you feel you want your therapist to know about your condition to better treat you.

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## MEDICAL SCREENING QUESTIONNAIRE

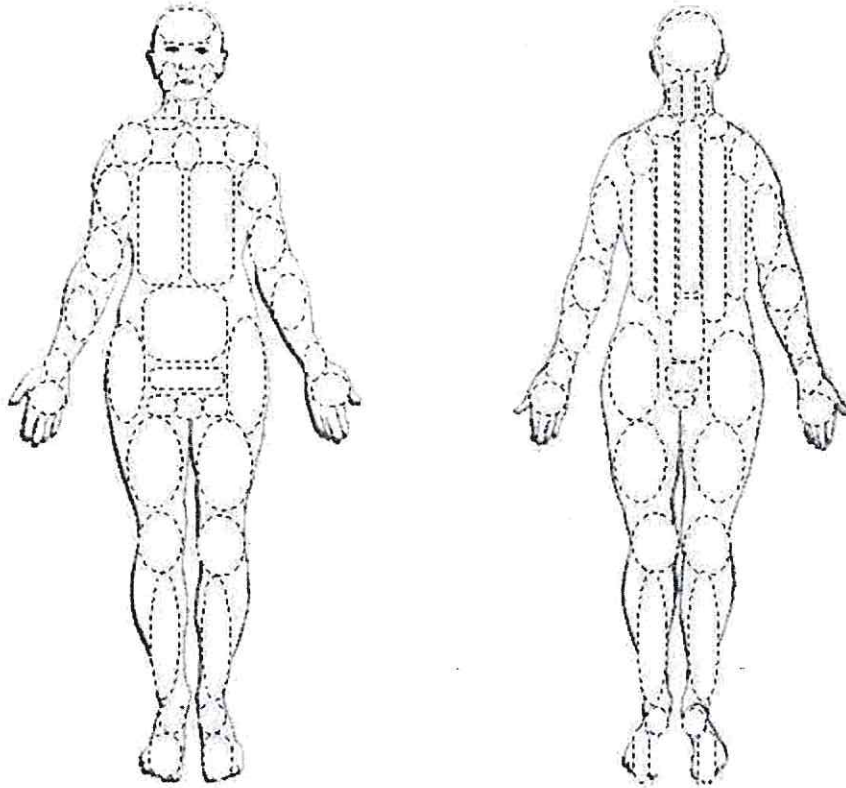
### Other health problems that may affect your treatment (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Arthritis (rheumatoid/osteoarthritis)  | <input type="checkbox"/> Visual Impairment (such as cataracts, glaucoma, macular degeneration)            |
| <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Hearing Impairment (very hard of hearing, even with hearing aids)                |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Back Pain (neck pain, low back pain, Degenerative Disc Disease, Spinal Stenosis) |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS) or Emphysema | <input type="checkbox"/> Kidney, bladder, prostate or urination problems                                  |
| <input type="checkbox"/> Angina   | <input type="checkbox"/> Previous accidents   |
| <input type="checkbox"/> Congestive Heart Failure (or heart disease)  | <input type="checkbox"/> Allergies  |
| <input type="checkbox"/> Heart Attack (Myocardial Infarction)   | <input type="checkbox"/> Incontinence   |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Anxiety or Panic Disorders   |
| <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's)   | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Stroke or TIA  | <input type="checkbox"/> Other disorders  |
| <input type="checkbox"/> Peripheral Vascular Disease  | <input type="checkbox"/> Hepatitis, Tuberculosis, HIV, AIDS or other blood-borne conditions               |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Prior surgery  |
| <input type="checkbox"/> Diabetes Type I or II  | <input type="checkbox"/> Prosthesis/implants  |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)                             | <input type="checkbox"/> Sleep Dysfunction  |
| <input type="checkbox"/> Pacemaker  | <input type="checkbox"/> Cancer   |

## PQRS Measure 131, Pain Assessment

Patient ID #:	Survey Date: ____ / ____ / ____
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Please mark all of the areas where you are experiencing pain on the body part diagram below:



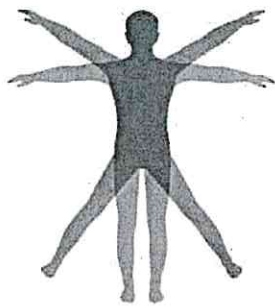
Please review all the qualities in the list below that describe your pain and circle the intensity for each one selected:

Throbbing	Severe	Moderate	Mild
Shooting	Severe	Moderate	Mild
Stabbing	Severe	Moderate	Mild
Sharp	Severe	Moderate	Mild
Cramping	Severe	Moderate	Mild
Gnawing	Severe	Moderate	Mild
Hot / Burning	Severe	Moderate	Mild
Aching	Severe	Moderate	Mild
Heavy	Severe	Moderate	Mild
Tender	Severe	Moderate	Mild
Splitting	Severe	Moderate	Mild
Tiring / Exhausting	Severe	Moderate	Mild
Sickening	Severe	Moderate	Mild
Fearful	Severe	Moderate	Mild
Punishing / Cruel	Severe	Moderate	Mild

**PQRS MEASURE 154: FALL RISK ASSESSMENT**

Patient ID: \_\_\_\_\_ Survey Date: \_\_\_\_\_

1. Are you wheelchair bound, non-ambulatory?  
☐ Yes *If Yes, please answer Questions 2, 3 & 4 and Stop*  
☐ No *If No, continue to #2*
2. Have you fallen in the last year?  
☐ Yes *If Yes, continue to #3*  
☐ No *If No, stop*
3. Did you sustain an injury from the fall?  
☐ Yes *If Yes, continue to #4-8*  
☐ No *If No, continue to #4*
4. Have you had two or more falls in the past year?  
☐ Yes *If Yes, continue to #5-8*  
☐ No *If No to #3 AND #4, stop*
5. Do you have any of the following in your home? Please select all that apply to you.
  - ☐ Clutter where you walk
  - ☐ Exposed electrical cords
  - ☐ Furniture or other sharp edged items in the normal pathways through your house
  - ☐ Poor lighting
  - ☐ Raised doorway thresholds
  - ☐ Slippery floors
  - ☐ Steps and stairways
  - ☐ Throw rugs
6. How many medications do you currently take?
  - ☐ None
  - ☐ 1
  - ☐ 2
  - ☐ 3 or 4
  - ☐ 5 or more
7. Were you taking any of the following medications at the time of your fall(s)? Please select all that apply.
  - ☐ Any central nervous system, psychotropic medications
  - ☐ Sedative, hypnotics (sleeping medications)
  - ☐ Antidepressants (especially tricyclics)
  - ☐ Antisychotics/neuroleptics
  - ☐ Benzodiazapines ("nerve pills")
  - ☐ Cardiovascular drugs
  - ☐ Diuretics
  - ☐ Antiarrhythmics
  - ☐ Cardiac glycosides
  - ☐ Diabetes medication
8. If you were taking any of the above at the time of your fall(s), are you still taking the medications?
  - ☐ Yes
  - ☐ No



# VPT

VICTORIA PHYSICAL THERAPY, P.C.

**Individual's Financial Responsibility:**

- I understand that I am financially responsible for my health insurance deductible, co-insurance or any non-covered services.
- Co-payments are due at any time of service.
- If my plan requires a primary care referral, I must obtain it prior to my visit.
- If my health plan determines a service to be "non-payable", I will be responsible for the complete charge for the medical services rendered to me.
- If I fail to provide current insurance cards or change insurance carriers and fail to notify my provider, I understand I am financially responsible for the complete charge for medical services rendered to me.
- If for any reason your insurance denies payment, we will do our best to collect the debt owed for our services. In the event they refuse payment, you will be responsible to pay. We are always open for you to pay at our "self-pay" price and will gladly discuss this at your request. You have the right to file your insurance claims yourself, for reimbursement from your insurance company, and we will help you any way we can.
- I understand, Victoria Physical Therapy, PC is filing my insurance as a courtesy to me and ultimately, I am financially responsible for medical services rendered to me.

Unfortunately, some insurance companies have become increasingly difficult to work with, and we have had many incidents where they change reimbursement requirements, without notification, and thus deny payment and refuse to reconcile or work with us.

We at VPT care about our patients and work very hard to help all our patients recover and get better. We value every one of our patients and we thank all of you for trusting us with your care.

Sincerely,  
The VPT Team

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Signature of Patient/Guardian of Patient

Date



## **VPT CANCELLATION POLICY**

Your safety and well-being are very important to us. During these unprecedented times we are doing our best to keep the number of people in the clinic to a minimum. We are doing this by reducing the number of patients each provider sees.

Because of this reduction in patients it is very important that each patient keep their appointment. At this time, we prefer as much notice as possible, and at least a 24-hour notice. If less than a 24-hour notice is provided we reserve the right to charge a cancellation fee of \$25.

Our cancellation policy:

- Any cancellation or reschedule made less than 24 hours will result in a cancellation fee of \$25.
- If you are more than 20 minutes late for your service, we will do our best to accommodate you but depending on the schedule we may not be able to. In this case, the same cancellation fee will apply. We will do our very best to reschedule your service for another time that is convenient to you.

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Signature of Patient/Guardian of Patient

Date



## PHOTO/VIDEO RELEASE FORM

- ☐ Victoria Physical Therapy, P.C. has my permission to use my photograph/video publicly to promote the company. I understand that the images or videos may be used in websites, social media, or presentations. I also understand that no royalty, fee or other compensation shall become payable to me by reason in such use.
  
- ☐ Victoria Physical Therapy, P.C. does **NOT** have my permission to use my photograph/video publicly to promote the company.

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

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

Phone Number: \_\_\_\_\_