VICTORIA PHYSICAL THERAPY, P.C.

3412 Sam Houston Dr.
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 #: _____

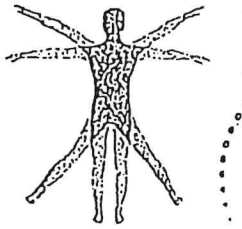
Relationship to Patient: Self Spouse Dependent (Child)

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.

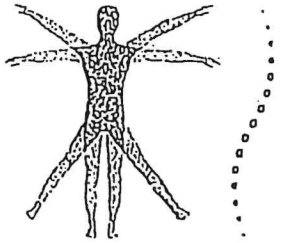
MEDICAL RELEASE FORM

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, P.T., DPT, CEEAA
Victoria Ortiz-Sheffel, PT, DPT



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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, P.T., DPT, CEEAA
Victoria Ortiz-Sheffel, PT, DPT

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 $2,330.00 for the year 2024;

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

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

- ☐ Personal comfort items.
- ☐ Most shots (vaccinations).
- ☐ Hearing aids and hearing examinations.
- ☐ Most outpatient prescription drugs.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Services required as a result of war.
- ☐ Routine physicals and most tests for screening.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Cosmetic surgery.
- ☐ Dental care and dentures (in most cases).
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim.
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- ☐ 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).
- ☐ 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.
- ☐ 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.
- ☐ Services of an assistant at surgery without prior approval from the peer review organization.
- ☐ 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: _____

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VICTORIA PHYSICAL THERAPY, P.C.

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):

_____

_____

_____

_____

_____

Explain your regular exercise routine:

_____

_____

_____

_____

_____

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 bowl, bladder or sexually related activities/functions? Yes/ No

I am currently experiencing (check all that apply):

- ☐ Difficulty swallowing
- ☐ Numbness/tingling
- ☐ Depression
- ☐ Unexplained weight loss
- ☐ Nausea/vomiting
- ☐ Increased pain at night/rest
- ☐ Bowl/bladder changes
- ☐ Shortness of breath
- ☐ Changes in appetite
- ☐ Headaches
- ☐ Poor balance, falls or dizziness
- ☐ Pain with menstruation
- ☐ Vision changes
- ☐ Pain with eating

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):

- ☐ Lying down
- ☐ Bending
- ☐ Standing
- ☐ Walking
- ☐ Turning in bed
- ☐ Stress
- ☐ Sitting
- ☐ Reaching overhead
- ☐ Lifting
- ☐ 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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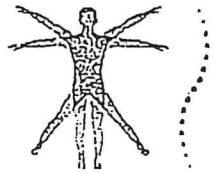
MEDICAL SCREENING QUESTIONNAIRE

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

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



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My Medicine Record

These are my medicines as of: _____

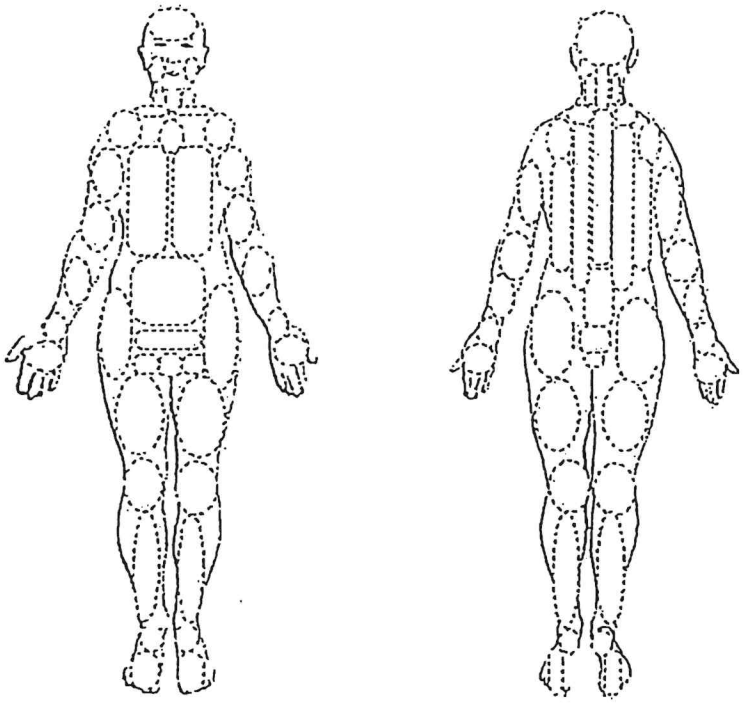
NAME: _____ BIRTH DATE: _____

	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					

PQRS Measure 131, Pain Assessment

Patient ID #:	Survey Date: ____/____/_____

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
   - ☐ Diurectics
   - ☐ Antiarythmics
   - ☐ 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

3412 Sam Houston Dr.

Victoria. Texas 77901

Tel: 361-578-3513

Facsimile: 361-578-4623

OUR MISSION

To serve our communities with compassion and respect as we promote their health and well-being.

OUR VALUES

Compassion, Accountability, Respect, and Responsibility.

PATIENT ACKNOWLEDGEMENT

APPOINTMENT CANCELLATION POLICY

Dear Patient,

Victoria Physical Therapy has instituted an appointment Cancellation Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

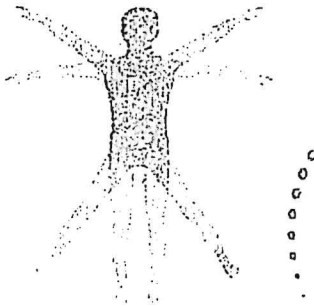
To remain consistent with our mission, we have instituted the following policy:

1. Please provide our office with **24-hour notice** in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service to avoid cancellation fee being charged.
2. A "No-Show", " No-Call" or missed appointment, without proper 24- hour notification, may be assessed a $25 fee.
3. If your appointment is for initial evaluation, the "No-Show", "No Call" or missed appointment fee is $50
4. This fee is not billable to your insurance. The patient is responsible for this fee.
5. If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled.
6. As a courtesy, we make reminder calls, for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.
7. Repeated missed appointments may result in termination of the physician/patient relationship.

If you have any questions regarding this policy, please let your staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you. Please sign and date below your acknowledgement.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Printed Name of Patient Signature of Patient Date



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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

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: _____