FREMONT THERAPY GROUP
Physical, Sports & Hand Therapy

PATIENT INFORMATION

Date:	]You will receive your billing statement via email/text and your patient payment portal. Please provide your email/cell phone information below.		
First Name	Last Name		Middle Initial
Home Address:	City:	St:	Zip:
Mailing Address:	City:	St:	Zip:
Landline Phone: ☐ Primary	Mobile Phone: ☐ Primary	Work Phone: ☐ Primary	
Email Address: I want to opt out of email statements and receive a paper statement ☐ I want to opt out of text appointment reminders ☐			
Social Security #:	Date of Birth:	Age:	Gender: ☐ M ☐ F
Driver's License #	Emergency Contact:	Telephone:	Relationship:
Place of Employment:	Employer Address:		

Referring Physician: _____ Phone Number: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment ☐ F/T Job ☐ P/T Job ☐ Retired ☐ F/T Student ☐ P/T Student ☐ None

Are you currently or have you received Home Healthcare in the last 60 days? ☐ Yes ☐ No

Have you been hospitalized in the last 60 days? ☐ Yes ☐ No

If yes to either question, who is your Home Healthcare Provider? _____

Have you had physical therapy treatment at another clinic this year ☐ Yes ☐ No

How did you hear about us?

☐ Physician/Hospital ☐ Returning Patient ☐ Word of Mouth (who) _____

☐ Internet Search/Website ☐ Other: _____

Injury Type: ☐ Work ☐ Auto ☐ Home ☐ Other Date of injury: _____

If this is a Worker's Compensation claim, who is the Employer? _____

Is an Attorney involved? ☐ Yes ☐ No Name Telephone:

Primary Insurance:	Medicare ☐ Yes ☐ No If Yes - ☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)		
Subscriber Name:	Relationship to patient::	Birth Date	Group/Policy
Secondary Insurance:	Medicare Secondary ☐ Yes ☐ No If Yes - ☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)		
Subscriber Name:	Relationship to patient:	Birth Date	Group/Policy#

Patient or Rep Signature: _____ Witness: _____ Date: _____

FREMONT THERAPY GROUP
Physical, Sports & Hand Therapy

ACKNOWLEDGEMENTS

FINANCIAL POLICY: As a courtesy, Fremont Therapy Group will bill your personal insurance carrier(s); however, you remain responsible for charges not covered by your insurance, including any interest and nonpayment fees. If you change insurance coverage while undergoing treatment, please notify our office of the change so we may adjust the billing records. We allow 60 days for your insurance carrier to remit payment to us before requesting payment from you. If the insurance company makes any payment directly to you for services billed by Fremont Therapy Group, please promptly remit the payment(s) to our office for proper account credit. In the event your insurance company requests a refund of payments made to Fremont Therapy Group, you may be responsible for the amount refunded to your insurance company.

Benefits quoted to us by your insurance carrier are not a guarantee of benefits, are subject to change, are not all-inclusive, and may have coverage limitations related to terms of your contract with your insurance company, terms of any direct or indirect contract we hold with the payer, and your specific insurance plan's interpretation of the medical necessity of the services provided. Please refer to your insurance plan's applicable benefit agreement to determine any limitations or exclusions for your rehabilitation services. Fremont Therapy will work with you to correct any errors related to our documentation; however, we are not responsible for errors made by your insurance carrier. We have reviewed these benefits with you and you agree to pay your portion of this bill.

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for Fremont Therapy Group to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

CONSENT FOR TREATMENT IF A MINOR: I authorize Fremont Therapy Group to treat _____ while I am not present. (Minor's name, if applicable)

PRIVACY AND SECURITY: I acknowledge that I was offered a copy of Fremont Therapy Group's Privacy and Security Notice and Compliance Plan in print and online at www.fremonttherapygroup.com.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Fremont Therapy Group to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. We may charge for cancellation without proper notice for a physical therapy visit. This charge will not be covered by insurance.

CO-PAYMENTS: Co-payments are due at the time of service.

NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds may be subject to a $35 processing fee.

Disclosures to Individuals Involved in Patient's Care:

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a moment to complete this section.

I authorize Fremont Therapy Group (FTG) to disclose my health information that is directly related to my current treatment at FTG to the individual(s) listed below for purposes of their role in my treatment or payment for the services I have received. Such persons involved in your care may include: spouse, parents, children, relatives, domestic partners, significant others, colleagues, etc.

Name	Relationship

_____ _____

Patient/Guardian Signature Date

Please Print Name

Relationship to patient; self, guardian, etc.

PATIENT/GUARDIAN/RESPONSIBLE PARTY SIGNATURE

DATE

FREMONT THERAPY GROUP
Physical, Sports & Hand Therapy

MEDICAL SCREENING

Name: _____ Date: _____ Gende ☐ Male ☐ Female

Date of Birth: _____ Occupation _____ Currently working? ☐ Yes ☐ No
Height: _____ Weight: _____

CURRENT CONDITIONS:
Where are you currently having symptoms?

_____

When did these symptoms start? _____

How did this injury occur? ☐ Gradually ☐ Suddenly ☐ Injury

PleaseDescribe _____

My symptoms are currently ☐ Getting Better ☐ About the Same ☐ Getting Worse

Please list any previous treatment for this condition

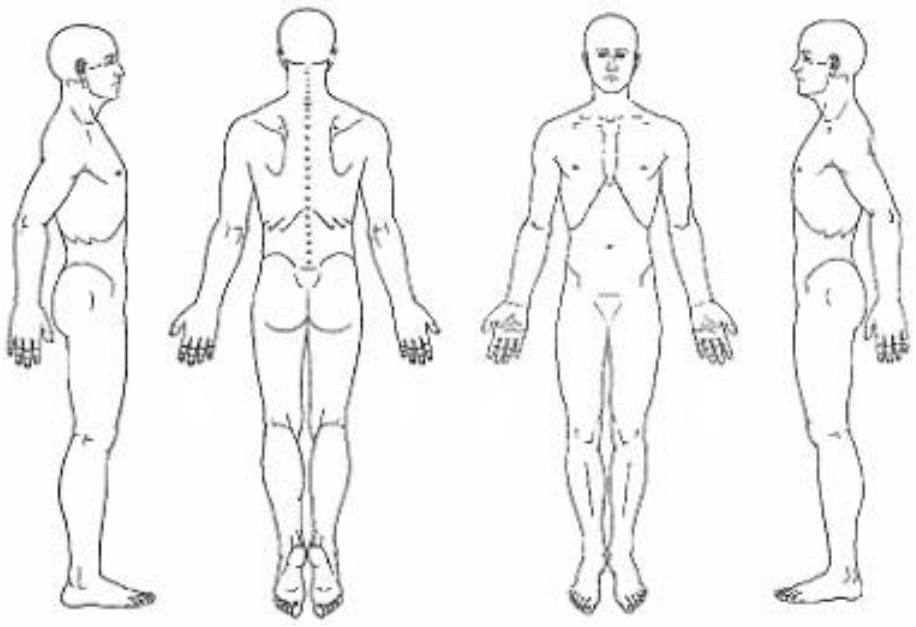
_____

_____

Have you ever had this problem before? ☐ Yes ☐ No
If yes, how was the problem treated _____
Have you had any imaging studies done for this problem (x-rays, MRI, etc)? ☐ Yes ☐ No

Please use the following symbols to note symptom location on the diagrams below:

X – Pain
O – Numbness
!!! – Pins & Needles



Check the box below the number that represents your worst level of pain over the past week:

NoPain	0	1	2	3	4	5	6	7	8	9	10	WorstPain
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Check the box below the number that represents your average level of pain over the past week:

NoPain	0	1	2	3	4	5	6	7	8	9	10	WorstPain
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Check the box below the number that represents your best level of pain over the past week:

NoPain	0	1	2	3	4	5	6	7	8	9	10	WorstPain
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

FREMONT THERAPY GROUP
Physical, Sports & Hand Therapy

MEDICAL SCREENING

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem:

1. 2. 3.

Currently, I am experiencing the following (check all that apply):

☐ Unexplained Weight Loss ☐ Difficulty Swallowing ☐ Dizziness
☐ Increased Pain at Night ☐Headaches ☐ Depression
☐ Fever / Chills / Sweats ☐Nausea/Vomiting ☐ Shortness of Breath
☐ Changes in Bowel or Bladder Function ☐ Shingles ☐ Other

Have you fallen in the past 12 months? ☐ No ☐ Yes If yes, how many times? _____

Did you sustain any injuries from these falls? ☐ No ☐ Yes If yes, describe: _____

Do you feel unsteady when standing or walking? ☐ No ☐ Yes If yes, describe: _____

Do you worry about falling? ☐ No ☐ Yes If yes, describe: _____

CURRENT and/or PAST MEDICAL HISTORY:

☐ High Blood Pressure ☐ Stroke ☐ Arthritis
☐ Lung Disease/Problems ☐ Cancer ☐ Kidney Disease
☐ Heart Disease/Problems ☐ Liver Disease ☐ Diabetes ☐ Before 18 ☐ After 18
☐ Asthma/Allergies ☐ Pacemaker ☐ Angina
☐ Circulation/Bleeding Problems ☐ Osteoporosis ☐ Fibromyalgia

Are you allergic to latex? ☐ Yes ☐ No Are you allergic to steroids? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

During the past month, have you often felt down, depressed or hopeless? ☐ Yes ☐ No
During the past month, have you often felt little interest or pleasure in doing things? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No

If so, please list ALL medications you are currently taking. Please include dose/frequency or provide a list:

1. 3. 5.
2. 4. 6.

Please list past surgeries and dates:

Surgery _____ Date _____

Please list any medical conditions you have that have not been documented above:

1. 3. 5.
2. 4. 6.

What are your physical therapy and/or fitness goals? (Write out or complete the sentence that applies.)

Decrease pain with -
Improve ability to -

Are you currently physically active? ☐ Yes ☐ No

FREMONT THERAPY GROUP
Physical, Sports & Hand Therapy

PRIVACY & SECURITY

FREMONT THERAPY GROUP
COMPLIANCE PROGRAM
PRIVACY AND SECURITY COMPLIANCE PLAN
PRIVACY AND SECURITY NOTICE

Fremont Therapy Group, in compliance with certain laws, has taken reasonable and comprehensive steps towards the protection of the privacy and security of your personal health information. Such information may include oral, written, telephone, facsimile and/or other electronic communication of protected health information (PHI).

Complete information regarding Privacy and Security Practices is available to all patients upon individual request and such information is entitled "Statement of Privacy and Security Practices."

Individual Patient Rights: You have rights with respect to the following:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Further Information/Concerns: Please express any concerns you may have regarding any violations of your privacy rights and other privacy and security issues to the Fremont Therapy Compliance Officer. Any concerns reported will not result in retaliation or retribution.

Compliance Officer:

Compliance Officer
1300 West Sam Houston Pkwy S.
Suite 300 Houston, TX 77042
Telephone: (713) 344-0351
Fax: (713) 430-4044
Email: Compliance@usph.com

You also have the right to report any concerns regarding your privacy rights to the Secretary of the US Health and Human Services Department. The Department can be contacted at http://www.hhs.gov/ocr/hipaa or by calling (800) 368-1019. By signing below, you acknowledge that you were offered a copy of this form and have read its contents.

FREMONT THERAPY GROUP
Physical, Sports & Hand Therapy

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to th information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Choices

You have some choices in the way that we use and share your information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and othe
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say, "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are unable to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.