Austin Regional Clinic
Physical Therapy
Information Packet

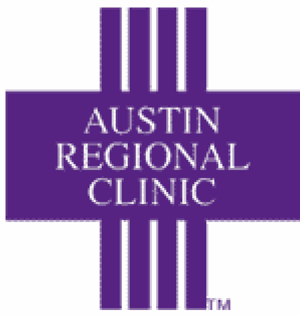
Therapist: ____________________

Appointment Date: ____________________

Appointment Time: ____________________

- ❑ Referral Form from your Physician
- ❑ Complete the following and bring with you:
  - ❑ Patient Questionnaire
  - ❑ Physical Therapy Medical Consent Form
  - ❑ Patients Rights/Responsibility Consent Form
- ❑ Wear comfortable clothing – like going to a gym
  - ❑ If seeing Physical Therapy for lower leg problem please wear shorts

❖ Most insurance carriers require a copay for physical therapy services. Please come prepared to pay this at the time of service. Under certain circumstances we do offer payment plans. You can contact your insurance company via the 1-800 number on your insurance card if you have any questions about your physical therapy benefits.



Physical Therapy New Patient Information

Welcome to Austin Regional Clinic at Physical Therapy! We appreciate the opportunity to treat you. There are a few things that you need to know to make your appointment run smoothly.

- Please remember to bring your referral/prescription and any other information your primary care provider gave you.
- Please fill out the paperwork that is provided in this packet prior to your appointment time. If your paperwork is not completed, please arrive at least 15 minutes earlier than your appointment time in order to complete the paperwork.
- If you arrive more than 15 minutes after your scheduled appointment time, we may need to reschedule your appointment.
- Your initial appointment and follow up appointments will last approximately 45 minutes.
- Please dress comfortably, as if you were going to workout at a gym. (If you are seeing us for a lower leg problem, please wear shorts.)
- If there are two or more consecutive missed appointments without prior notification, then we may have to cancel any remaining visits and you will be referred back to your doctor.
- If you need to cancel/reschedule your appointment, please call at least 24 hours in advance to allow us to offer your appointment time to other patients.
- You can contact your insurance company via the 1-800 number on your insurance card, if you have any questions concerning your physical therapy benefits.

Again, thank you for choosing Austin Regional Clinic Physical Therapy.

Sincerely,
ARC-PT Staff

Austin Regional Clinic Physical Therapy

SUMMARY OF BASIC PATIENT'S RIGHTS AND RESPONSIBILITIES

We are committed to serving you with compassion, care, skill and respect. As one of our patients, you have choices, rights and responsibilities.

YOU HAVE THE *RIGHT:*

- To be treated with dignity and respect
- To know the names and professional status of the people serving you
- To privacy
- To confidentiality of your records of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side-effects and problems of all forms of treatment
- ***To participate in choosing a form of treatment***
- To consent to, or refuse, any care of treatment
- To select and/or change your health care provider
- To review your medical records with your clinician
- To information about services and any related costs

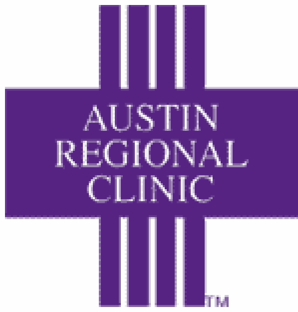
YOU HAVE THE *RESPONSIBILITY:*

- To keep appointments or cancel in advance
- ***To be honest about your medical history***
- To ask about anything you do not understand
- To follow treatment advice and medical instructions
- To report any significant changes in symptoms or failure to improve
- To understand your insurance policy regarding physical therapy benefits
- To respect clinic policies
- To provide both positive and negative feedback about services and policies

CONSUMER INFORMTATION NOTICE:

Complaints regarding non-compliance with the Physical Therapy Act, or regarding any licensee under the Act, should be directed to the:

Texas Board of Physical Therapy Examiners
333 Guadalupe, Suite 2-510
Austin, Texas 78701-3942
512-305-6900
Toll Free 800-821-3205 (Complaints Only)



Austin Regional Clinic
Physical Therapy
Copay Information

- Since different plans charge different copays for physical therapy, please check with your specific policy about benefits.

- If your insurance plan requires a deductible or charges a percentage, we will bill your insurance and the remaining amount will be billed to you.

- If your insurance plan requires a copay, we will collect that during the visit. Copays are usually the *specialty copay* and will be collected at each visit unless payment arrangements have been previously set up.

- Under certain circumstances we do offer payment plans. If you are in need of a payment plan, please speak with the front desk.

- You can contact your insurance company via the 1-800 number on your insurance card, if you have any questions concerning your physical therapy benefits.

Thank you,

ARC Physical Therapy Staff

Updated 06/20/07

Rehabilitation Screening/Confidential Medical History

Patient's Name: _________________________________Age:________ Date:_____________

Please complete the following questions to the best of your ability. This will help us to develop a treatment with you that meet your individual needs.

1. Reason for this visit? ____
2. Date of injury or when problem began: ____
   a. Date it worsened (if applicable): ____
3. How did your current problem begin? ____ lifting ____ twisting ____ falling ____ motor vehicle accident
   _____ unknown _____bending _____ other: ____
4. Were you hospitalized for this problem? _____ yes _____ no If yes, give dates:______________________
5. Did you have any diagnostic tests (Xrays, MRI, CT Scan)?____
   Results?____

6. Please mark the areas where you have seen a decline in your abilities with your most recent condition:

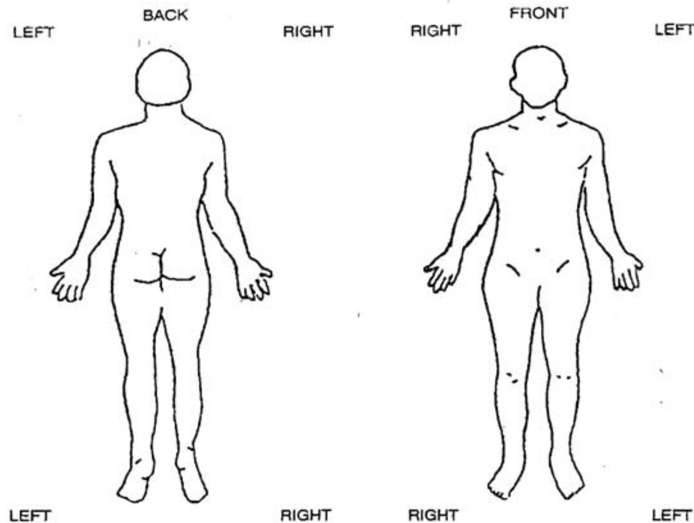
- ☐ Getting in/out of bed
- ☐ Rising from sitting
- ☐ Walking
- ☐ Balance
- ☐ Driving
- ☐ Dressing/Grooming
- ☐ Turning head/trunk
- ☐ Exercise routine
- ☐ Lifting
- ☐ Bending
- ☐ Working
- ☐ Sleeping/resting
- ☐ Sitting
- ☐ Carrying objects
- ☐ Standing
- ☐ Lying down
- ☐ Coughing/Sneezing
- ☐ Sleeping
- ☐ Other: ______________________________________

____

7. Have you experienced similar symptoms before? __ yes __ no
   a. Indicate on the body diagrams where your symptoms occur:

Check any that you are experiencing:

- ❑ Aching
- ❑ Stabbing
- ❑ Pins & needles
- ❑ Numbness
- ❑ Burning



b. Rate your pain using the following scale, with one being the least amount of pain and 10 being very severe pain::

During rest:	1	2	3	4	5	6	7	8	9	10:
During activity	1	2	3	4	5	6	7	8	9	10

Patient's Name: ________________________________

8. Are you presently working? ___ yes _____ no. Occupation:_______________________________
   If working, is it _____ light/modified duty ___ regular duty?

9. What type of exercise do you regularly perform (prior to injury) and how often? ____________________

   ____

   What hobbies are you involved in?__________________________

10. Have you ever been diagnosed with any of the following?

___Cardiac Problems	___Diabetes	___ Asthma	___Infectious Disease
___Hypertension	___Osteoarthritis	___Orthopedic Problems	___Autoimmune Disease
___ Pacemaker	___Rheumatoid Arthritis	___GI problems	___Stroke/TIA
___Cancer	___Seizures	___Multiple Sclerosis	___Open wound
___ Fibromyalgia	___Depression	___Drug/Alcohol Dependency	

11. Have you ever had a broken bone or fracture? _____ yes _____ no If yes, which body part:____ When:_________________________

12. Please list any major surgeries with dates:____

____

____

13. Any previous physical therapy, chiropractic care or other treatment? ______ yes ______ no

14. Do you smoke? _____ yes _____ no If yes, number of packs/day? ___________________

15. Are you pregnant? _____ yes _____ no

16. List any medication allergies or latex allergy:____

____

17. List all prescription or over-the-counter medications you are currently taking **or provide us with a separate list:**

____

____

____

____

18. What are your goals for physical therapy?

____

____

19. Is this a work-related injury? _____yes ______no
    If yes, will this be filed through your personal insurance or worker's compensation? _________________

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name:______________________________ DX:_________ Number of Visits:________

Using the key below please circle one answer in each box that indicates your ability to do the following activities;

Key: (0 = unable) (1 = very difficult) (2 = moderately difficult) (3 minimally difficult) (4= normal)

Activity	Score				
1. Sleep normally	**0**	**1**	**2**	**3**	**4**
2. Up and Down Stairs	**0**	**1**	**2**	**3**	**4**
3. Food Prep/Cooking/Eating	**0**	**1**	**2**	**3**	**4**
4. Walking	**0**	**1**	**2**	**3**	**4**
5. Grooming(bath, comb hair, shave, etc)	**0**	**1**	**2**	**3**	**4**
6. Getting up/down from chair or bed	**0**	**1**	**2**	**3**	**4**
7. Dressing – manage normal dressing activities.	**0**	**1**	**2**	**3**	**4**
8. Lifting/Carrying up to 10 pounds.	**0**	**1**	**2**	**3**	**4**
9. Sitting for normal periods of time	**0**	**1**	**2**	**3**	**4**
10. Standing for normal periods of time	**0**	**1**	**2**	**3**	**4**
11. Reaching above head or across body	**0**	**1**	**2**	**3**	**4**
12 .Recreational/Sports Activities	**0**	**1**	**2**	**3**	**4**
13. Squatting down to pick up item.	**0**	**1**	**2**	**3**	**4**
14. Running/Jogging	**0**	**1**	**2**	**3**	**4**
15. Driving	**0**	**1**	**2**	**3**	**4**
16. Job Requirements – can do all activities required of my job.	**0**	**1**	**2**	**3**	**4**

Pain Scale - Please circle the number that describes the pain you have experienced over the last week with 0 being no pain and 10 the worst imaginable had**.**

0	1	2	3	4	5	6	7	8	9	10

Office Use

	64

<u>**Austin Regional Clinic Physical Therapy**</u>

Consent for Treatment

Patient's Name:_________________________________ Date:________________

I hereby authorize the therapists at Austin Regional Clinic Physical Therapy Department to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I have received and reviewed a copy of the:

- **New Patient Information**
- **Patient Rights and Responsibilities**.
- **Copay Information**

____

(Authorized Signature) (Date)

Updated 05/30/07