

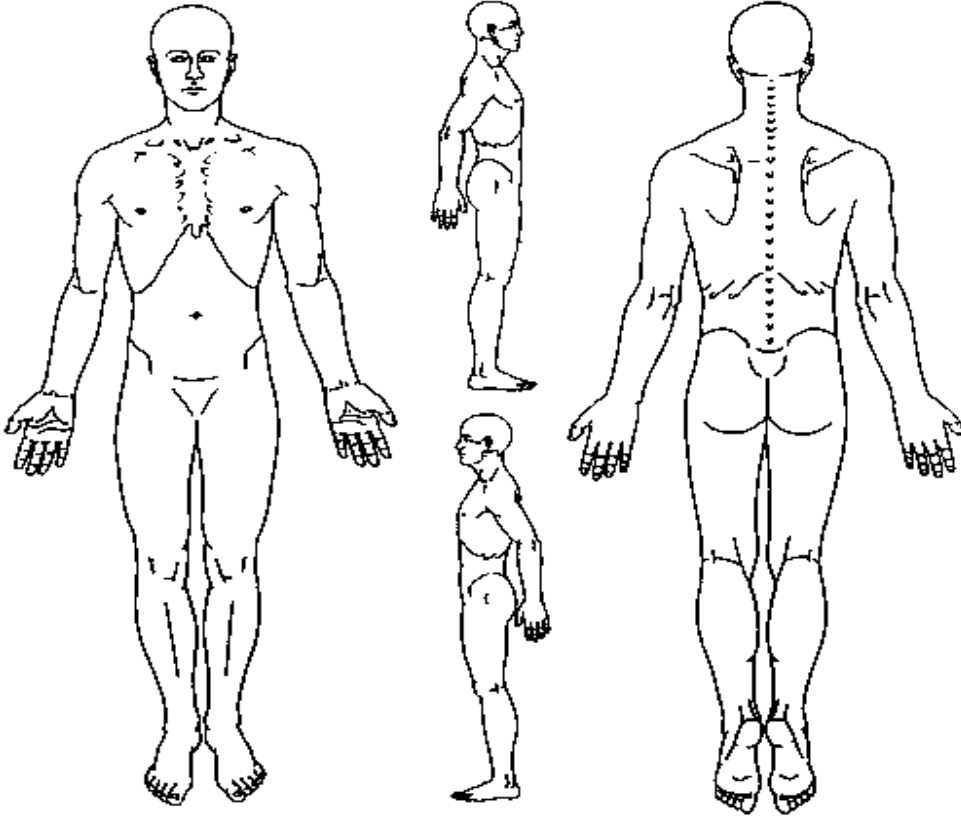


**Physical Rehabilitation & Wellness**

Name \_\_\_\_\_

How long have you had this pain \_\_\_Years\_\_\_Months\_\_\_Weeks\_\_\_Days

**Please show us where it hurts?**



**OFFICE STAFF ONLY**

DEXTERITY R L

DATE OF SUR \_\_\_\_\_

BP: \_\_\_\_\_ MM/HG

TEMP: \_\_\_\_\_ DEG

RST PUL: \_\_\_\_\_ BPM

HGT: \_\_\_Ft\_\_\_Inc

WGT: \_\_\_\_\_ LBS

**FUNCTIONAL OUTCOME SCORE**

- NDI \_\_\_\_\_
- FLEX SF \_\_\_\_\_
- DASH \_\_\_\_\_
- FABQ SCORE \_\_\_\_\_
- (Only WC LBP/ must complete with Oswestry)
- OSWESTRY \_\_\_\_\_
- 3 LEA \_\_\_\_\_
- LYSHOLM \_\_\_\_\_ (ACL/meniscus)
- OXFORD \_\_\_\_\_ (TKR only)
- 3 ANKLE A \_\_\_\_\_
- FFI \_\_\_\_\_
- LEFS \_\_\_\_\_ (Multi. LE)
- SF36 \_\_\_\_\_ (Multiple areas of body)

**My pain is:** \_\_\_ Constant \_\_\_ Intermittent (relieved in some positions or rest) \_\_\_ Occasional (daily or less frequent) \_\_\_ Infrequent (once a week or month) \_\_\_ Variable (sometimes worst than others) \_\_\_ No longer present

**My pain is:** **C** = CRAMPING **B** = BURNING **E** = ELECTRICAL **S** = SHARP **D** = DULL  
**O** = OTHER (PLEASE SPECIFY) \_\_\_\_\_

**INDICATE YOUR PAIN LEVEL AT REST**

\_\_\_\_\_ 0\_1\_2\_3\_4\_5\_6\_7\_8\_9\_10 (0 = NO PAIN AT ALL AND 10= WORST PAIN I HAVE EVER HAD)

**INDICATE YOUR PAIN LEVEL WITH ACTIVITY**

0\_1\_2\_3\_4\_5\_6\_7\_8\_9\_10 (0 = NO PAIN AT ALL AND 10= WORST PAIN I HAVE EVER HAD)

What makes your pain better? \_\_\_\_\_

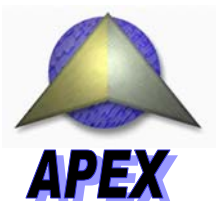
What makes your pain worst? \_\_\_\_\_

\_\_\_\_\_

Patient signature/Date

\_\_\_\_\_

Clinician signature/Date



**Physical Rehabilitation & Wellness**

**Name:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Age:** \_\_\_\_\_

**What area/areas of your body is injured:** \_\_\_\_\_

**Was your injury Due to Auto accident or work related? Yes\_\_ No\_\_**

**When did you hurt yourself/or notice the pain?** \_\_\_\_\_

**What Caused / do you think caused your current problem?** \_\_\_\_\_

**Aside from decreasing your pain, what are your goals for therapy?**

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

**Are you currently working? \_\_Yes\_\_No If no date last worked?** \_\_\_\_\_

**Treatment to date for this injury: \_\_Physical therapy \_\_MD/DO \_\_Chiropractor  
\_\_Injections/Blocks \_\_Other\_(please specify) \_\_\_\_\_**

**Tests performed: \_\_X-ray \_\_ MRI \_\_CT Scan \_\_EMG \_\_ Doppler\_\_ Ultrasound\_\_  
Bone Scan \_\_ Other\_\_\_\_\_**

**What were the results of the tests (if known)** \_\_\_\_\_

\_\_\_\_\_



**Physical Rehabilitation & Wellness**

**Past Medical History: *Place a checkmark below if you have:***

- |   |  |
|---|--|
| <input type="checkbox"/> Heart Disease/problems (specify)     | <input type="checkbox"/> Psychological complications (specify) |
| <input type="checkbox"/> Blood circulation problems (specify) | <input type="checkbox"/> Arthritis                             |
| <input type="checkbox"/> Stroke (when? _____)                 | <input type="checkbox"/> Broken Bones (Where?_____)            |
| <input type="checkbox"/> Blood pressure (low__high__)         | <input type="checkbox"/> Digestive complications (specify)     |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Neurological complications (specify)  |
| <input type="checkbox"/> Respiratory complications            | <input type="checkbox"/> Hepatitis (A) (B) (C)                 |
| <input type="checkbox"/> Balance Deficits                     | <input type="checkbox"/> Rheumatism                            |
| <input type="checkbox"/> Cancer (type _____)                  | <input type="checkbox"/> Kidney complications                  |
| <input type="checkbox"/> Diabetes type I__ type II__          | <input type="checkbox"/> Thyroid hypo_ hyper_                  |
| <input type="checkbox"/> Dizziness                            | <input type="checkbox"/> Osteoporosis                          |
| <input type="checkbox"/> Incontinence                         |  |
| <input type="checkbox"/> Headaches                            | <input type="checkbox"/> others not listed (please specify)    |
| <input type="checkbox"/> Seizures                             | _____  |
|   | _____  |

*Also Place a circle around the items above if anyone in your immediate family has been known to have had any of the above complications*

**Females Only: Date of last menstrual cycle (if applicable) \_\_\_\_\_**

	Yes	NO
• If Female are you pregnant	_____	_____
• Are you wearing a pace maker/ Defibrillator or other electric device	_____	_____
• Any Type of Surgery	_____	_____
• Difficulty going to the bathroom	_____	_____
• Shortness of breath	_____	_____
• <b><u>Excessive</u></b> Fatigue	_____	_____
• Wheezing or Prolonged Cough	_____	_____
• <b><u>Unexplained</u></b> Weight Change Of more than 10Lbs	_____	_____
• Fever and/or Chills	_____	_____
• Pain that awakens you From sleep	_____	_____
• <b>DO You</b> Smoke yes/no		If yes How Much _____
	Drink yes/no	If yes then How Much _____





**Physical Rehabilitation & wellness**

7575 SAN FELIP #125  
HOUSTON, TEXAS 77063  
PH. 713-270-5900  
FAX 713-270-5910

4610 SWEETWATER BLVD, #120  
SUGAR LAND TEXAS 77479  
PH. 281 -242 -5252  
FAX: 281-242-5256

10021 S.MAIN, SUITE B-2 (Main Medical Plaza)  
HOUSTON, TEXAS 77025  
PH: 832-209-7235  
FAX: 832-209-7240

**Patient Information:**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Sex: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

HM Phone: \_\_\_\_\_ CELL Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer: \_\_\_\_\_ Ph: \_\_\_\_\_ Patient SSN: \_\_\_\_\_  
( ) Single ( ) Married ( ) Other

**Responsible Party Information:** ( ) SAME AS ABOVE

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Ph: \_\_\_\_\_

**Primary Insurance Information:**

Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured's SSN#: \_\_\_\_\_ Relation to Patient: ( ) Self ( ) Spouse ( ) Parent

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Ph: \_\_\_\_\_

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

**Secondary Insurance Information:**

Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Insured's SSN#: \_\_\_\_\_

Relation to Patient: ( ) Self ( ) Spouse ( ) Parent

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Ph: \_\_\_\_\_

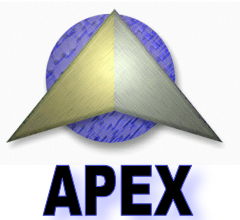
Policy #: \_\_\_\_\_ Group: \_\_\_\_\_

**Acknowledgement and Authority**

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever form of physical rehabilitation, functional abilities evaluation, or other diagnostic studies that may be used by the attending therapist, or his or her qualified designate. I have been informed of potential risks and benefits of treatment. I acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service, unless other arrangements are made with the financial department. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. APEX Physical Rehabilitation & wellness will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable period of time. I authorize APEX Physical Rehabilitation & Wellness to release information required as to my insurance or third party payor (including my employer's workmans' comp carrier, if applicable), for purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse, and/or mental health issues. I also authorize APEX Physical Rehabilitation & wellness to bill my insurance or third party payor, and receive payment directly from them for services rendered. This authorization shall remain valid for a period of 2 years, or until such time as I revoke it in writing. A photo copy or faxed copy of this authorization shall be deemed as valid as the original. I also understand that my failure to attend 3 scheduled sessions, without prior notification, can result in my release from the care of Apex Physical Rehabilitation and wellness. In addition I also understand that each failure to attend will result in a cancellation of fee of \$75.00 unless a 24 hour cancellation notice is provided by me.

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

*Patient/Guardian of Patient*



**Clinic and Attendance Policy**

Welcome! We would like to take this opportunity to welcome you to Apex Physical Rehab & Wellness and to thank you for choosing our organization for your physical rehab & Wellness needs. We are constantly striving to make our offices more efficient and to provide the best possible service to you. In an effort to do so we ask that you help us with the following:

- In order to receive the maximum benefit from your rehabilitation program, it is of utmost importance that you attend all of your therapy appointments and follow the instructions. Appointments are given on the hour (Ex: 0900 am, 1000am, 1100am etc.). Patients who are more than 15 minutes late may have to wait until the next available time slot. If you will be late or need to change your appointment please contact the front desk of the facility that has you scheduled; be aware that changes are subject to availability. **Treatment time is limited to a maximum of 1 hour from the time you are brought back to the treatment area. Please respect the next patient's/therapist's appointment time and depart upon completion of treatment. Please refrain from using cell phones during treatment.**
- We request that you notify us if you are unable to keep your appointment. In such case please notify the receptionist 24 hours prior to you scheduled appointment. **Failure to attend an appointment will result in a \$75.00 fee. You may reschedule any scheduled appointment time on the same date, subject to availability, without a penalty. Failure to attend 3 scheduled sessions, without prior notice, can result in release from our care with notification sent to you and your physician. In addition, patients, covered by workers' compensation, that fail to attend appointments will have their claims adjuster and treating physician notified and may have their case sent for review or denial.**
- It is your responsibility to schedule your appointments at least one week in advance; in fact we encourage you to schedule your entire treatment in advance if you can.
- Your appointments can be on any day of the week just not 3 days in a row.
- Please do not ask any of the staff about the conditions of other patients being treated as it violates ethical and privacy standards.
- Please advise the receptionist of other physician appointments to avoid a schedule conflict.
- If scheduling due to work is a concern we can provide your employer with a note specifying the days and the times that you will be attending therapy.
- Medical records are available upon request and have a fee. Please allow 24-48 hours for processing. **The patient in person must pick up the records only at Memorial clinic.**
- We require you to wear the appropriate attire for treatment. T-shirts, sweat shirts, shorts, sweatpants and tennis shoes are preferred. Open toe sandals and high heels are not allowed.
- Any person accompanying the patient will need to wait in the designated waiting area for the sake of safety and privacy. Only patients will be allowed in the treatment area. Another adult must accompany children under the age of 10.
- **Your insurance will be billed unless other arrangements have been made. You may receive monthly statements/bills. If you have concerns regarding billing/statements please only contact the Memorial Office@ 713 270 5900. The therapists/receptionists do not have the authority/information to answer billing questions.**
- Exceptions to the above policy are considered on a case-by-case basis. If you have any questions or feel that you have a special situation that requires special consideration: please contact the front office as soon as possible

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I have read and understand the attendance policy at Apex Physical Rehab and Wellness and agree to comply

\_\_\_\_\_ Signature of patient or responsible party



## Physical Rehabilitation & Wellness

### Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

1) This practice is permitted to make uses and disclosures of protected health information for treatment, Payment and health care operations, as described in the following examples:

a) For treatment - consultation, lab work, pharmacy, x-ray, etc. b) For payment - claim filing, collection payment due, etc. c) For health care operations - chart maintenance, regulatory requirements, accounting, HIPAA compliance activities, etc.

2) This practice is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.

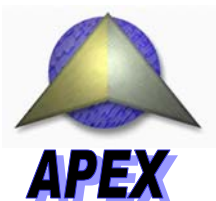
3) This practice may engage in the following activities: a) this practice may contact the individual or other immediate adult family members to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.

4) The individual has the following rights regarding protected health information: a) the right to request restrictions on certain uses and disclosures of protected health information. This practice is not required to agree to a requested restriction, however. b) the right to receive confidential communications of protected health information, as applicable. c) the right to inspect and copy protected health information, as provided in the Privacy Regulation d) the right to amend protected health information, as provided in the Privacy Regulation. e) the right to receive an accounting of disclosures of protected health information. f) the right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information. This practice is required to abide by the terms of the Notice currently in effect. This practice reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. The practice will provide individuals or patients with a revised Notice as requested. Individuals may complain to this practice, and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. Complaints may be submitted in writing to paramount health services LLC Dba Apex Physical therapy & Fitness 7575 San Felipe Ste.125, Houston,TX, 77063. This Practice's Contact for matters relating to complaints is: Jim Marzouki @ 713 270 5900 or you may contact: **OFFICE FOR CIVIL RIGHTS (OCR) @ (214) 767-4056 FAX (214) 767-8940, US DEPT OF HEALTH & HUMAN SERVICES, 1301 YOUNG ST., STE 1169 , DALLAS , TX 75202.** This notice is first in effect on April 14, 2003. This practice can elect to limit the uses or disclosure that it is permitted to make by law.

\_\_\_\_\_  
Individuals Signature

\_\_\_\_\_  
Date



**Physical Rehabilitation & Wellness**

Name \_\_\_\_\_

**Home Health Episode/Previous Treatment.**

1. Are you currently seeking any type of treatment from a home health agency?

Yes \_\_\_\_ No \_\_\_\_

If yes what is the agency's name? \_\_\_\_\_ Phone \_\_\_\_\_

Name of contact person at the home health agency \_\_\_\_\_

2. Have you received benefits from a home health agency in the past?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes provide dates:

3. Are you being visited by a nurse at your home at this time?

4. Does anyone come to your home to provide any type of assistance to you?

5. Have you had any type of home assistance within the last 6 months?

6. Are you or have you received any type of therapy at home or in an office with in the last 6 months? If so please provide an estimated date and the name of the office.

**By Signing below I attest that the above information is true to the best of my knowledge. I further understand that having received recent home health services may have limited my Medicare coverage. I also understand that limitation of Medicare coverage as a result of having had recent /previous physical rehabilitation services may make me liable for any outstanding bills due to physical or occupational therapy treatment by paramount health services LLC, DBA Apex physical therapy & Fitness.**

\_\_\_\_\_  
Signature

Date \_\_\_\_\_



**Physical Rehabilitation & Wellness**

**PATIENT CONSENT FORM**

**CONSENT TO TREATMENT.** Knowing that I have a condition requiring health care, I voluntarily consent to such health care, including diagnostic procedures and medical treatment ordered by my physicians. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations.

**JOINT NOTICE OF PRIVACY PRACTICE.** I acknowledge that I received a copy of the Joint Notice of Privacy Practice and that I have had the opportunity to review it and ask questions. If I refuse to accept receipt of the Joint Notice, I acknowledge that a good faith effort was made to present me with the document and my reason for refusing to accept this section and receipt of the Joint Notice is \_\_\_\_\_

Do not write above unless refusing to accept receipt

**ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER.** I understand that, if a health care worker is accidentally exposed to my blood or other body fluids, I will be tested for Hepatitis B, Hepatitis C, or HIV/AIDS without my specific consent. Test results will be kept confidential to the extent allowed by law.

**TOBACCO-FREE ENVIRONMENT.** I am aware that all Paramount health services LLC facilities are tobacco-free environments and that the use of any tobacco product, except in designated areas, is strictly prohibited.

**PROHIBITION OF DRUGS, ALCOHOL, AND WEAPONS.** I understand that Apex physical rehabilitation's policy prohibits the consumption, use, or possession of non-prescribed drugs (including controlled substances, such as marijuana, cocaine, or heroin), alcohol, and weapons on its property. If non-prescribed drugs, alcohol, or weapons are found, they will be confiscated, and I may be discharged immediately. Local police authorities will be notified, if appropriate.

**PERSONAL ITEMS.** I have been advised to leave my personal items at home and assume responsibility for any personal items that I take to my room or treatment area. I understand that paramount health services and its facilities will not be responsible for any personal items that are lost, stolen, or damaged.

**FINANCIAL RESPONSIBILITY.** In return for the services rendered to me by paramount health services LLC, I promise to pay paramount health services in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment either because the plan deems such services not medically necessary or for any other reason.



**Physical Rehabilitation & Wellness**

(Check all that apply)

**ASSIGNMENT OF BENEFITS.** I assign to Paramount health services LLC all benefits payable to me under my insurance policies and health benefit plans.

**MEDICARE ASSIGNMENT.** I certify that the information given by me in applying for Medicare benefits is correct. I request that payment of authorized benefits be made directly to Paramount health services LLC.

**MEDICAID ASSIGNMENT.** I certify that the information given by me in applying for Medicaid benefits is correct. I request that payment of authorized Medicaid benefits be made directly to Paramount health services LLC .

**WORKERS' COMPENSATION.** The Worker's Compensation Commission regulates fees and charges for medical aid, health care and medicines. For those services provided which the Commission determines not to be work related, I understand that I am financially responsible. In the event of such determination, the following insurance may be billed with benefits payable to the provider of service: \_\_\_\_\_

Name of private health insurance carrier in case claim is not covered by work comp.

**REQUEST FOR "NO INFORMATION" STATUS.** I request "No Information" status, which means that my name and my presence in a paramount health services will not be divulged, except for judicial Process.  YES  NO

**THIS CONSENT IS VALID UNTIL REVOKED OR CHANGED. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT AT PARAMOUNT HEALTH SERVICES.**

Signature of Patient (or Patient's Representative) \_\_\_\_\_ Date \_\_\_\_\_

**Verbal Consent given**  
(Only if the patient is incapable  
Of signing)

\_\_\_\_\_  
WITNESS (ONLY IF INCAPABLE OF SIGNING)

\* If the patient is incapable of signing or gives verbal consent, please state why:

**Minor** (any unmarried individual who has not reached age 18 or is not otherwise emancipated).

**Physically Impaired**

**Cognitively Impaired**

**Other** \_\_\_\_\_ Relationship of signer to patient: \_\_\_\_\_