Devic Physical Therapy
Strength, Mobility, Function

DEVIC PHYSICAL THERAPY LLC
4041 W. Wheatland Rd, #130 Dallas TX 75237
Phone # (469) 877-5207, Fax # (469) 361-8226

Pre-Exam Form

Patient's First Name:	**Middle Initial:**	**Patient's Last Name:**

Age:		**Sex:**	Male	Female	**Date of Injury/Issue:**	
Have you fallen in the past 12 months?	☐ YES ☐ NO	**If yes, how many times?**				
Have any falls resulted in an injury?		**Do you worry about falling?**	☐ YES ☐ NO			

Describe BREIFLY why you are coming to therapy:

_____

List ONE ACTIVITY you are unable to do or are having difficulty performing that you absolutely want to improve or to be able to do again:

_____

What are your goals/expectations from therapy?

_____

On a scale of 1 to 10, What is your CURRENT pain level:									
1	2	3	4	5	6	7	8	9	10
(Low)				(Moderate)					(Severe)
On a scale of 1 to 10, What was your WORST pain level in the past couple of days:									
1	2	3	4	5	6	7	8	9	10
(Low)				(Moderate)					(Severe)
On a scale of 1 to 10, What was your BEST/least pain level in the past couple days:									
1	2	3	4	5	6	7	8	9	10
(Low)				(Moderate)					(Severe)

Type of Pain (circle all that apply):					
Dizziness	Dull	Throbbing	Sharp	Stiffness	Deep Ache
Superficial	Burning	Pins & Needles	None	N/A	

Duration of Pain/Dizziness (circle all that apply):			
Pain with Sitting	Constant	Night Pain	Intermittent (Comes & Goes)
Occasional Pain with Standing	Pain with Walking	At Random	N/A

Do you have a pacemaker?	☐ YES	☐ NO		
Are you currently pregnant?	☐ YES	☐ NO		
If yes, how many weeks?				
Smoking:	Frequently	Occasionally	Rarely	Never
Alcohol Consumption:	Frequently	Occasionally	Rarely	Never
Are you allergic to adhesives/tape or latex?	☐ YES	☐ NO	☐ Unknown	
Any other allergies (please list, if any)?				

Have you had any recent imaging (MRI, X-ray, etc.)? When? And results, if known?

_____

List any medications you are taking (if none, please write N/A)

_____

_____

List all past surgeries with dates (if none, please write N/A)

_____

_____

Please mark if you have or have had any of these conditions:

_N/A
_AIDS/HIV
_ALLERGIES
_ASTHMA
_BALANCE PROBLEMS
_CANCER
_BLOOD CLOTS/CLOTTING
_DISORDER
_CHF
_DIABETES
_COPD FALLS
_EMPHYSEMA
_EPILEPSY
_GOUT
_HEART DISEASE
_HEART ATTACK
_HEADACHE
_HEART SURGERY
_LOW BLOOD PRESSURE
_LUNG DISEASE
_OSTEOPOROSIS
_SLEEP APNEA
_TMJ/JAW PROBLEMS
_STROKE
_SUBSTANCE ABUSE
_PROBLEMS
_KIDNEY DISEASE
_TREMORS
_HIGH BLOOD PRESSURE
_CIRCULATORY PROBLEMS
_OSTEOPENIA
_DIZZINESS
_SEIZURES
_FACIAL DROOPING
_BLURRED/DOUBLE VISION
_ARTHRITIS
_ATTENTION/ CONCENTRATION PROBLEMS
_HEP B/HEP C
_ANXIETY
_ARRHYTHMIA
_SCOLIOSIS

Please mark if you have recently experience any of the following:

_N/A
_ATTENTION/CONCENTRATION PROBLEMS
_BALANCE PROBLEMS
_BRONCHITIS
_BLOOD CLOTS
_CONSTANT PAIN _UNRELIEVED BY REST OR MOVEMENT
_CHANGE IN BOWEL OR BLADDER HABITS
_DIZZINESS
_DIFFICULTY SLEEPING
_DIFFICULTY WALKING
_HEADACHE
_HOARSENESS (PROLONGED)/ NAGGING COUGH
_OBVIOUS CHANGE IN WART OR MOLE
_PREGNANT
_SORE THAT WILL NOT HEAL
_UNUSUAL BLEEDING OR DISCHARGE
_UNEXPLAINED WEIGHT LOSS
_DIFFICULTY SITTING
_BLURRED/DOUBLE VISION
_CIRCULATORY PROBLEMS
_FALLS
_UNUSUAL FATIGUE
_INDIGESTION OR DIFFICULTY SWALLOWING
_SHORTNESS OF BREATH
_AGINA/CHEST PAIN
_DISLOCATION
_CURRENT INFECTION

List any other medical conditions you have (or were told you have) that were not address above (i.e. PD, Bipolar Disorder, MS, RA, Fibromyalgia, GERD, etc.):

_____

_____

BY CHECKING & SIGNING BELOW YOU ARE CONFIRMING THE FOLLOWING:

☐ I agree & understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Signature of Patient (or Legal Guardian): _____ Date (MM/DD/YYYY): _____

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Intake Form

Patient's First Name:	**Middle Initial:**	**Patient's Last Name:**

Physical Home Address:	
Phone Number (Home/Cell):	
Phone Number (Secondary Contact Number):	

May we send you email messages for your appointment reminders to the email provided (text/call are not possible at this time).	☐ YES	☐ NO
May we send you emails relating to your care with us? By selecting YES, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.	☐ YES	☐ NO

Referring Physician (if applicable):	
Primary Care Physician (needed for Authorizations/Pre-approvals	

Primary Reason for visit (please circle):	Back	Leg/Foot	Neck	Other	
	Shoulder/Hand	Balance	Dizziness/Vertigo		
Are you currently receiving, or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc.) in the last 60 days?	☐ YES	☐ NO			
Are you currently receiving or have you received other therapy services in the last 60 days?	☐ YES	☐ NO			
Marital Status (please circle):	Married	Single	Widowed	Divorced	
Employment Status (please circle):	Working	Part-time	Retired	Not Employed	Disabled

Please fill out your insurance information as best as you can, if unsure, the front office can assist you at the time of your appointment.

Primary Insurance	***Secondary Insurance***
Policy Holder's Name:	Policy Holder's Name:
Holder's Birth Date:	Holder's Birth Date:
Policy or Certificate #:	Policy or Certificate #:
Group #:	Group #:
Policy Holder's Employer (if applicable):	Policy Holder's Employer (if applicable):

How did you hear about us (please circle)?

Physician	Insurance	Former Patient	Website	Word of Mouth (Friend/Family/Former Patient)
Marketing AD (Facebook/Instagram/Yelp/Google Search)			Marketing AD – PRINT (brochure, Mailer, Business Card, AD in Magazine)	

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IMPORTANT RULES & POLICIES

1. **Late Policy:** If I 'm more than 10-minutes late to my appointment, I may be rescheduled or asked to wait for the next available open time slot.
2. If possible, please give a 3-hour advance notice for changes to appointment for general courtesy.
3. There is no late or no-show fee for established patients, **unless 3 consecutive appointments** have been missed as no call/no show and then a **cancellation fee of $25** will be applied to your account.
4. Co-pays and/or deductibles are due prior to treatment starts.
5. There will be a $25.00 fee for medical records 25 pages or less, and for any medical records more than 26 pages, there will be a $50.00 fee.
6. Cell phones must be shut OFF or silent.
7. Children requiring supervision are NOT allowed to attend sessions with you without prior authorization.
8. If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.
9. If for any reason, you are NOT satisfied with the care received, please call us at (469) 877-5207

Emergency Contacts (Up to 3 may be listed) – Please include Name, Relationship, Contact Number
1.
2.
3.

DISCLOSURE OF MEDICAL RECORDS – Please include Name, Relationship, Contact Number I authorize the following individuals (Up to 3 may be listed) to have access to knowledge of my physical presence at this facility and provide information about my scheduling, medical billing and general condition, to those persons listed below who are personally interested in my whereabouts and progress (if same as emergency contacts – please check "Same as above" below):
1.
2.
3.

☐ Same as above

By checking & signing below you are confirming the following:

☐ I agree and understand the Important rules & policies of Olive Physical Therapy and that all information provided is accurate to the best of my ability.

Signature of Patient (or Legal Guardian): _____ Date (MM/DD/YYYY): _____

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Liability, Authorization & Patient Consent Form

Liability:

☐ I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

☐ I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

☐ I know and agree that Olive Physical Therapy is not responsible for loss or damage to personal valuables.

☐ I acknowledge that the rehabilitation therapy services may involve direct or indirect bodily contact.

☐ I hereby release, discharge and acquit: Olive Physical Therapy it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from **my refusal to accept, receive or allow emergency and or medical services** including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

☐ I acknowledge the activities in which I will engage as part of the treatment provided by DEVIC PHYSICAL THERAPY LLC and the physical therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities: my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability.

Financial:

☐ This does not pertain to me as I choose not to involve my insurance company and agree to pay for services in full.

☐ I understand that Olive Physical Therapy must obtain a copy of my photo identification and current valid insurance card at the first visit to assist in filling my insurance claim and to protect me from insurance fraud.

☐ I authorize release of payment directly to Olive Physical Therapy regardless of participation in or out of network.

☐ I agree to satisfy all insurance co-payments, co-insurance, and deductibles on the day services are rendered.

☐ I understand that I am responsible for informing the office of any changes that occur with my insurance. Failure to provide the necessary information may result in my claim being denied and I will become responsible for the balance of all charges.

☐ Non-covered Services: Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by the insurers. We will assist you in making every attempt to receive verification of your policy. If for any reason your claim is denied, you are responsible for the full amount. Please contact your insurance company to determine your benefits to avoid any unexpected charges for which you will be held responsible. All insurance benefits vary and therefore it is not possible for us to know which services are not covered under your specific plan. I understand I am responsible for any charges not covered by my insurance carrier.

☐ I understand that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Authorization:

☐ I hereby assign and direct payment of my benefits directly to DEVIC PHYSICAL THERAPY LLC for any services furnished to me by the providers.

☐ I authorize release of any medical records and personal health information (PHI) to other healthcare providers and other third parties as necessary to process my claims and supply information as otherwise permitted or required in the Notice of Privacy Practices.

☐ I authorize that a photograph or paper copy of this letter shall be considered as effective and valid as the original.

☐ I authorize Olive Physical Therapy to call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying our treatment, payment and operations.

☐ I authorize Olive Physical Therapy to contact me by phone, mail, text or email to participate in marketing events, satisfaction surveys and pertinent products or services offered.

☐ I acknowledge that any photographs taken by DEVIC PHYSICAL THERAPY LLC and/or its employees and contractors will become part of my **medical record** and may be disclosed in accordance with DEVIC PHYSICAL THERAPY LLCNotice of Privacy Practices.

☐ I acknowledge that my **consent** for pictures of myself will be **required** before any photographs will be taken.

☐ Despite the risk that information transmitted electronically or through facsimile (fax) communication devices may be intercepted or inadvertently transmitted to people not authorized to receive the information, I hereby authorize the transmission of any medical record, or any part thereof, electronically and through facsimile (fax) communication devices.

HIPPA Notice of Privacy/Patient Bill of Rights Acknowledgement:

☐ I have received the Notice of Privacy Practices and Patient Bill of Rights and/or I have been provided with an opportunity to review it (located at the front office or **https://devicphysicaltherapy.com/**).

☐ I understand that my consent may be withdrawn or restricted by me, in writing, except to the extent authorized information has been disclosed in reliance upon it.

☐ Olive Physical Therapy's Notice of Privacy Practices explains how my medical information will be used and disclosed. If you would like a copy for your records, please request at the front desk.

☐ Olive Physical Therapy reserves the right to revise its HIPAA Notice of Privacy Practices at any time. A revised HIPPA Notice of Privacy Practices may be obtained by request at the front desk or through https://devicphysicaltherapy.com/

☐ Federal Law protects the confidentiality of the patients of this facility. It is unlawful to disclose any information about a patient, even their name to anyone. By signing into this facility, you agree to abide by these Federal Laws and not disclose any information or the identity of anyone here.

Consent To Treatment:

☐ I hereby **consent** to medical treatment and associated services at DEVIC PHYSICAL THERAPY LLC for my present physical condition.

☐ I certify that all of the information provided herein is true and correct to the best of my ability.

☐ I understand by signing I am giving my permission for treatment and acknowledgements of all Liabilities, Financial Policies, and Authorizations. In any event, this **consent shall expire 1 month after my discharge** from this facility.

☐ I also understand any disclosure made on my behalf by this facility is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

BY CHECKING & SIGNING BELOW YOU ARE CONFIRMING THE FOLLOWING:

☐ I acknowledge the above Liabilities, Financial Policies, Authorizations, HIPPA Notice of Privacy/Patient Bill of Rights Acknowledgement and give My Consent for treatment to DEVIC PHYSICAL THERAPY LLC.

Signature of Patient (or Legal Guardian): _____ Date (MM/DD/YYYY): _____