



2758 N Galloway Ave, Suite 100
Mesquite, TX 75150
Phone 972-681-1155
Fax 972-681-3575

Please fill these forms out completely and bring them to your first office visit.

Additional Items to Bring to Your First Visit:

- Prescription for physical therapy from your referring physician
- Government issued, photo ID (such as a driver's license)
- Insurance card(s)
- Appropriate attire (workout clothes)
- Patients who are minors (under 18 years of age) must be accompanied by a parent or guardian for their first visit

PATIENT INTAKE MEDICAL HISTORY

PATIENT'S NAME _____ AGE _____ HEIGHT _____ WEIGHT _____

OCCUPATION _____ WHEN WAS THE LAST DAY YOU WORKED ? _____

CONDITION/INJURY BRINGING YOU TO PHYSICAL THERAPY TODAY: _____

PLEASE DESCRIBE HOW THIS OCCURRED: _____

WHAT DOCTORS HAVE YOU SEEN FOR THIS CONDITION ? _____

SPECIAL TEST PERFORMED FOR THIS CONDITION () X-RAY () MRI () CT SCAN () BONE SCAN () EMG () DISCOGRAM

HAVE YOU RECEIVED ANY TYPE OF THERAPY FOR THIS CONDITION ? () YES () NO

IF YES, WHAT TYPE AND WHEN DID THIS OCCUR: _____

HAVE YOU HAD SURGERY FOR THIS CONDITION ? () YES () NO

IF YES, WHAT TYPE AND WHEN DID THIS OCCUR: _____

LIST CURRENT MEDICATIONS YOU ARE TAKING: _____

DO YOU HAVE ANY CURRENT PROBLEMS OR PAST HISTORY OF/WITH:

- BLOOD PRESSURE () YES () NO DIABETES () YES () NO ASTHMA () YES () NO
HEART CONDITION () YES () NO STROKE () YES () NO ARTHRITIS () YES () NO
CIRCULATION () YES () NO CANCER () YES () NO SEIZURES () YES () NO
AIDS/HIV POSITIVE () YES () NO ALCOHOLISM () YES () NO SMOKING () YES () NO
MIGRAINES () YES () NO NEUROLOGICAL () YES () NO

ARE YOU PREGNANT NOW OR IS THERE A CHANCE THAT YOU ARE PREGNANT ? () YES () NO

DO YOU HAVE AN ADVANCED DIRECTIVE ON FILE ? () YES () NO

DESCRIBE YOUR NORMAL JOB: _____

ARE YOU ABLE TO PERFORM THESE ACTIVITIES NOW ? () YES () NO

DESCRIBE YOUR NORMAL RECREATIONAL ACTIVITIES: _____

ARE YOU ABLE TO PERFORM THESE ACTIVITIES NOW ? () YES () NO

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ? _____

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

REVIEWED / SIGNED BY THERAPIST: _____ DATE: _____

PATIENT & INSURANCE INFORMATION

PATIENT

Patient Name _____ Employer _____
Address _____ Address _____
City/State/Zip _____ City/State/Zip _____
Hm. Phone _____ Work Phone _____
Social Security # _____ Birthdate _____ M/F _____ Marital Status _____
Emergency Contact _____ Phone _____
Did your injury occur at: work _____ auto _____ other _____ Date of Injury _____
Type of injury _____ Prior Physical Therapy? _____
Are you a student athlete? (Y/N) _____ If yes, name of school _____

GUARANTOR /INSURED PARTY (Please complete if different than patient)

Name _____ Relationship to Patient _____
Address _____ Employer _____
City/State/Zip _____ Address _____
Phone _____ Birthdate _____ City/State/Zip _____
Social Security # _____ Phone _____

RELEASE OF INFORMATION

All information provided herein is true and correct. I hereby consent to treatment.

I give permission to VISTA Rehabilitation and its affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employers, school, related healthcare provider, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance purposes.

ASSIGNMENT OF BENEFITS

I authorize payment directly to VISTA Rehabilitation and its affiliates for services.

PAYMENT GUARANTEE

I agree to pay VISTA Rehabilitation and or its affiliates for the services provided to me or the party named above. If the law (W/C) or my payor contract prohibits my payment for these services, I will cooperate and or assist in the provision of information, releases, etc. to allow for speedy collection from my third party payor. Where the law or a payor contract does not prohibit payment by me I acknowledge responsibility for any/all account balances.

X _____ Date _____
Patient or Guardian Signature

All individuals shall be accorded impartial access to treatment regardless of race, gender, national origin, disability, health status, religion, age, sexual orientation or sources of payment for care.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Vista Rehab of Mesquite, L.L.P.

Patient Signature

Date

In lieu of patient signature, I, _____, a staff member of Vista Rehab of Mesquite, L.L.P. state that _____ has been given our current Notice of Privacy Practices.

Staff Member Signature

Date

NOTICE OF PRIVACY PRACTICES

Vista Rehab of Mesquite, L.L.P.

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- ◆ Make sure that health information that identifies you is kept private;
- ◆ Give you this notice of our legal duties and privacy practices with respect to health information about you;
- ◆ Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization. There are also various other ways in which we may use or disclose your information:

- ◆ To allow oversight of the quality of the healthcare we provide;
- ◆ To allow workers' compensation claims;
- ◆ As required by subpoena in lawsuits and disputes;
- ◆ Various uses as required by law or to avert a serious threat to health or safety.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- ◆ Right to inspect and copy;
- ◆ Right to amend;
- ◆ Right to an accounting of disclosures;
- ◆ Right to request restrictions;
- ◆ Right to request confidential communications;
- ◆ Right to a copy of this notice.

Information on how to exercise these rights can be seen in the Notice of Privacy Practices.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Craig Rettke, PT, Compliance Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION.

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.