Fax: 512.628.3422
Phone: 512.640.9965
ReachOutcomes.com

REACH PHYSICAL THERAPY

OFFICE POLICIES AND PROCEDURES

Welcome and thank you for choosing Reach Physical Therapy for your Physical Therapy needs. Under certain circumstances, the Texas Physical Therapy Board may require patients to have a written referral from a licensed medical person (MD, DO, DC, DDS, DPM, ANP, PA) prior to receiving physical therapy treatment. It is your responsibility to obtain and maintain a current referral prior to and during your treatment if required. If you do not have a referral for treatment, you will be asked to sign a separate disclosure form prior to treatment.

As a courtesy to others and our therapists, Reach Physical Therapy (RPT) requires a 24-hour cancellation notice. This allows others on waiting lists to be seen. RPT send make reminder emails on the day prior to your appointment, but it is always your responsibility to remember your time and day. Only emergencies or illnesses are excusable. A fee of $99.00 will be billed for no-shows without proper cancellation notice.

PAYMENT/BILLING POLICIES

RPT is a fee for service clinic. This means that payment is due at time services are rendered. RPT accepts cash, personal checks, debit cards, credit cards. There is a $25.00 fee for bounced checks. RPT reserves the right to refuse checks from individuals who have previously supplied a bounced check to RPT.

RPT is not a participating provider or member of most insurance networks and does not file insurance claims to obtain payment for your services. Unless you have been separately notified by RPT of its in-network status with your insurance carrier and RPT's intention to directly submit claims, RPT will not file an insurance claim to obtain payment for your services. RPT will provide you a receipt with diagnosis and treatment codes for you to submit to your insurance company for possible reimbursement. Unless a claim is submitted by RPT directly, all reimbursements from your insurance must be made out directly to you. If further reports or documentation are requested to obtain reimbursement from your insurance, RPT will provide the documentation. If your insurance company sends payment to RPT for claims you have submitted, RPT will return payment and a new check must be made to you personally.

RPT is not a Medicare provider. Medicare will not pay for services rendered by RPT even if such services are normally covered by Medicare. If you are a Medicare beneficiary, please notify RPT prior to receiving services.

Please clarify prior to checkout if you have any questions regarding charges or fees.

For treatment sessions with minors, the parent or guardian bringing the child to the appointment will be deemed the responsible party.

Fee Schedule for Physical Therapy Services:

Initial Evaluation: $200
60 minute treatmnent session: $160 ($40/15 minute unit)

NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you have been provided and have read RPT's Notice of Privacy Practices containing a more complete description of the uses and disclosures of your health information. Additional copies are available from our office upon request.

MEDIA RELEASE

By signing below, you grant RPT the right to reproduce the photographs and/or video images taken of you for the purpose of publication, promotion, illustration, advertising, and educational uses, in any manner or in any medium. You release RPT from all claims and liability relating to said images or video and waive any right to compensation.

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CONSENT TO TELEPHONE/EMAIL COMMUNICATION

By signing below, you also acknowledge that you understand that any phone or email communication will be part of your medical record. You understand that email communication is not secure and that it is not to be used for any emergent matters. RPT will make every effort to respond to email communications from patients within 3-5 business days. If you do not receive a response within that time, please call our office.

CONTACT PERMISSION

You hereby consent to allow RPT to contact you and transmit information, which may contain private health information, in the following manner: (Check all that apply)

- ☐ By email. Email address: _____
- ☐ Leave a message on an answering machine or voice mail. Phone # _____
- ☐ Speak with spouse/significant other. Name: _____
- ☐ Speak with other family members. Name: _____

CONSENT TO TREATMENT

RPT is a hands-on Physical Therapy practice which utilizes manual therapy and therapeutic exercise treatments. Examination and treatment techniques are based on current research and are performed by a Texas-licensed Physical Therapist with a Doctor of Physical Therapy degree. Forms of traction, deep tissue massage, therapeutic exercise programs, gait training, neuromuscular re-education, myofascial release, bone and soft tissue mobilization/manipulation, as well as other treatment modalities may be used. Some of the hands-on treatment techniques may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change to other parts of the body. These results are not unusual, however, please do ask if you have any concerns or questions. The number of treatments and recovery time can vary due to the age of injury, number of times injured, additional treatments received, age of patient and other contributing factors.

By signing below, you acknowledge that you have read and fully understand the above statement and that you understand the nature of the treatments at RPT. You hereby authorize RPT and RPT staff to use treatment techniques as deemed necessary for your safe and effective recovery.

You hereby consent to the above treatments and any others deemed necessary by RPT. Furthermore, You understand that by signing this form you hereby waive any right to file a claim based upon injury or discomfort from said treatment activities and the symptoms described above.

You understand that by signing this form that you indicate that you have read and understand the above written statements.

_____
Patient Name (Printed)

_____ _____
Signature of Patient/Legal Guardian Date

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PAST MEDICAL HISTORY FORM

Patient Name: _____ Age: _____

Please check all that apply and describe below. Do you now, or have you in the past, had any of the following (please also consider during and/or after exercise):

- ☐ Anemia
- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Blood Transfusion
- ☐ Bowel/Bladder Dysfunction
- ☐ Cancer
- ☐ Chest Pain/Angina
- ☐ Cholesterol Elevation
- ☐ Chronic Bronchitis
- ☐ Conclusion
- ☐ Deafness/Hearing Problem
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizures
- ☐ Fatigue
- ☐ Gallbladder Problems
- ☐ Gall Stones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Palpitations
- ☐ Heart Related Illness
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Hypothyroidism
- ☐ Kidney/Bladder Infections
- ☐ Kidney Stones
- ☐ Kidney Disease/Problems
- ☐ Liver Disease/Problems
- ☐ Loss of Appetite
- ☐ Lung Disease
- ☐ Menstrual Irregularities
- ☐ Metal Implants
- ☐ Migraines
- ☐ Muscle/Joint Injury
- ☐ Multiple Sclerosis
- ☐ Nausea/Vomiting
- ☐ Neurological Disorders
- ☐ Numbness/Tingling
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Prostate Trouble
- ☐ Rectal Trouble
- ☐ Respiratory Issues
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Ringing in your Ears
- ☐ Sickle Cell
- ☐ Skin Disease/Abnormalities
- ☐ Smoking
- ☐ Stroke
- ☐ Surgeries
- ☐ Thyroid Conditions
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vision Problems
- ☐ Viral Infection

Write any other conditions not listed above, or that could affect your treatment at Reach Physical Therapy:

_____

_____

_____

_____

What medication(s) are you currently taking and for what condition(s)?

_____

What supplements or vitamins are you currently taking?

_____

Are you on a special diet? ___ Yes ___ No Please describe: _____

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Have you gained OR lost a significant amount of weight in the last year? _____ Yes _____ No

If YES, please explain: _____

Referring provider, if applicable:

_____

Please describe current condition:

_____

Date of onset:

_____

List any treatments or activities that make your condition better or worse:

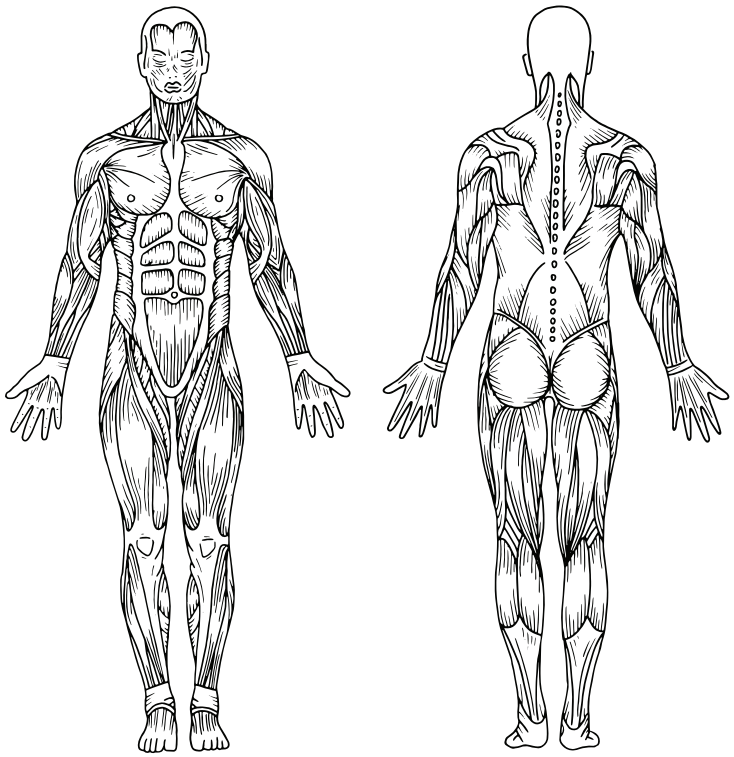
_____

_____

List any past tests that have been performed and their results (ex: X-ray, MRI, CT):

_____

_____



Please indicate on these figures where you are experiencing pain.

Use the following to describe pain on the figure.

PPP - Pain

TTT - Throbbing Pain

BBB - Burning Pain

ZZZ - Numbness

000 - Pins and Needles

Please rate the amount of pain you are currently experiencing on the chart below (please circle a number.)