South Austin Therapy Group

1825 Fortview Road, Suite 109
Austin, TX 78704
Phone: (512) 892-5250
Fax: (512) 892-7183
www.southaustintherapy.com

Thank you for scheduling an appointment with us!

Please print pages 2-6 & bring them to your first appointment.

Please arrive **15 minutes** prior to your appointment to allow us time to prepare your chart and to sign your insurance financial agreement. Please bring the following:

- Completed paperwork (please use black ink)
- Insurance cards
- Drivers license or other form of picture ID
- **Prescription from the referring physician for physical therapy,** unless it has already been sent to our office
- Your personal calendar for appointment scheduling
- Please wear comfortable clothes

Feel free to contact us with any questions or concerns; we look forward to helping you on the road to recovery.

Sincerely,

South Austin Therapy Group Staff

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CANCELLATION/NO SHOW & ATTENDANCE POLICY

We require that you notify our office **no later than 24 hours** before your scheduled appointment time if you need to cancel or re-schedule your appointment. Please contact the office and leave a voicemail if you are unable to speak with anyone.

Please be respectful of your appointment time and realize your attendance is important to your progression and recovery.

Please respect that we are a small business and a late cancel has a significant financial impact. We often operate on a waitlist, so proper notification allows another patient to be treated.

We will send a courtesy appointment reminder via text or email 24 hours before your next appointment, if requested at your initial appointment. Appointment reminders are not guaranteed and we recommend you keep your appointments on your personal calendar. **If you need to change an appointment, please call the office BEFORE you receive your reminder.**

- If you cancel your appointment with less than 24 hour notice or fail to show up to your appointment, you will be charged a $40 late cancellation fee.
- If you arrive 15 minutes late to your appointment start time, you will be charged a $25 late fee. Arrival later than 20 minutes can result in your therapist cancelling your appointment, and you will owe the $40 cancellation fee.
- If you have three (3) missed appointments (late cancels or re-scheduled appointments), no shows, or late arrivals your therapist has the right to discharge you from physical therapy.

Patient Signature: _____ **Date:** _____

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Patient Demographic Information

Today's Date: _____

First Name: _____ Middle Name: _____

Last Name: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: Female Male

Marital Status: Single Married Divorced Widowed

Address:_____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred number: Home Cell Work

Email address *(for appt reminder)* :_____

Employer: _____ Occupation: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____ Phone : _____

How did you find our clinic? Referring MD insurance family/friend website

Appointment Reminders:

We can send you an appointment reminder 24 hours before your appointment. Please check preferred method of reminder. Make sure the information is provided above.

_____: e-mail (*we will only use your email address for appointment reminders)*

_____: text message

_____: I do not want a reminder

PLEASE SEE CANCELLATION/NO SHOW POLICY. WE REQUIRE 24 HOUR NOTICE TO AVOID CHARGES

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Symptom Chart:

Patient Name: _____

Please describe your current condition:

_____

_____

_____

How long have you had this problem? _____ days _____ weeks _____ months _____years

Pain is: Constant Intermittent (on & off)

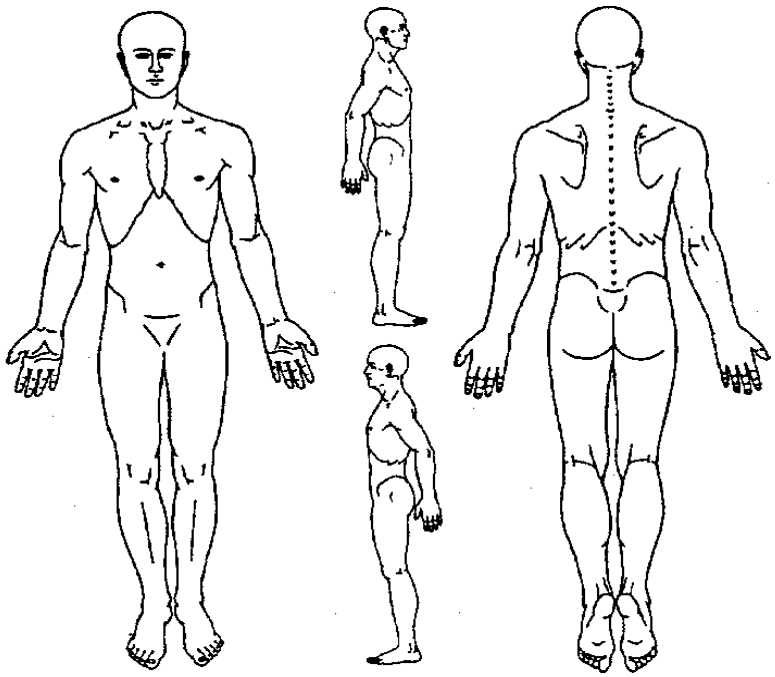
Pain Scale: Please rate the severity of symptoms on a scale of 0 to 10. 10 is severe pain.

Current pain: _____

Worst pain: _____

Please mark area(s) of injury or discomfort by labeling areas with the appropriate descriptors:

Description:	Numbness	Pins/Needles/Burning	Aching	Sharp
Symbols:	NNNN	BBBB	AAAA	SSSS



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Medical History Questionnaire:

Patient Name: _____ Current Weight: _____lbs Height: _____ ft ____ in

Known allergies:_____

List current medications & dosage. Please feel free to attach separate list:

_____

_____

_____

_____

Please indicate if you currently have or had in the past any of the following diseases or conditions:

Y N Alcoholism
Y N Anemia
Y N Anxiety
Y N Arthritis
Y N Blood Pressure
Y N Cancer, type: _____
Y N Circulatory Problems
Y N Depression
Y N Dizziness
Y N Drug Abuse
Y N Diabetes
Y N Fractures
Y N Frequent/Recent Falls
Y N GI Disturbance
Y N Gout
Y N Hearing Problems
Y N Heart Disease
Y N Immune System
Y N Incontinence: Bladder
Y N Incontinence: Bowel
Y N Joint Replacement
Y N Liver Disease
Y N Mental Illness
Y N Neurological Conditions
Y N Osteoporosis
Y N Pacemaker
Y N Recent Weight Gain/Loss
Y N Renal (Kidney) Disease
Y N Respiratory
Y N Seizures
Y N Stroke
Y N Urinary
Y N Vision
Other:_____

Past surgical history: _____

Family history:

Y N Cancer, type:_____
Y N Diabetes
Y N Heart Disease
Y N Immune System
Y N Liver Disease

Do you smoke? Y N How many day_____ How long? _____
Have you smoked in the past? Y N Year quit: _____
Do you drink alcohol? Y N How often? _____

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Patient Consent Form & Assignment of Benefit

I have reviewed the office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

I hereby indicate my wish to be a participant in the rehabilitation program offered by South Austin Therapy Group. I understand that the purpose of this program is to enhance my recovery from an injury or illness. I further understand that there exists the possibility that certain changes may occur during my treatment.

I hereby authorize payment of all health benefits to South Austin Therapy Group and allow assignee to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as original. I understand that I am legally responsible for all charges incurred whether or not they are paid for by said insurance and that any unpaid balance shall be due in full immediately if insurance proceeds are paid to me.

I hereby authorized the release of medical records, inclusive or all results of testing and other pertinent information acquired during treatment, to the referring physician(s) and other consulting specialists.

I have reviewed this form and certify that all the information is correct to my knowledge.

_____ _____

Patient/Legal Guardian Signature Date