

PHYSICAL THERAPY

Policies and Procedures Orientation

The purpose of this information sheet is to inform patients of policies and procedures as they relate to their care as a patient at TSMC.

1. Patients' Rights and Responsibilities:

A Patients' Rights and Responsibilities pamphlet will be given to you upon registration at TRMC. Please take time to familiarize yourself with the contents of this pamphlet.

2. Prescription Requirements:

A valid, current prescription with a medical diagnosis from a medical physician is required in order for you to receive physical therapy (treatment) at TSMC. For the prescription to be valid it must be presented within thirty (30) days of the day in which it was written and must be signed by a medical doctor. The length of your rehabilitation stay and number of visits you are granted are dependant upon the specifics of the prescription and your insurance coverage. If the prescription expires and you have not completed the rehabilitation process, it is your responsibility to obtain a new prescription.

3. Initial evaluation and Introduction to Staff & Team Concept:

As a patient at TSMC you will have an initial evaluation by a licensed physical therapist. The initial evaluation will include: history, physical assessment, pain assessment, treatment plan, goals & objectives.

Treatment sessions are developed and evaluated by a physical therapist. TSMC's physical therapists are assisted in patient care by physical therapy technicians, student physical therapists and/or athletic trainers.

TSMC is an affiliation site for several Texas universities who offer curriculums in physical therapy. As a result we receive students from theses universities on a regular basis. Each of these students are in the final phases of their education and in order to qualify for graduation have to complete a minimum of four, 6 to 10 week clinical rotations in a variety of health care settings. The students who intern at TSMC must follow strict educational guidelines, and are supervised by TSMC staff physical therapists during their rotation period. If, as a patient, you prefer not to have a student physical therapist work you, please inform a staff physical therapist of your preference.

4. Appointments, Cancellations and "No-Shows":

Appointments are scheduled with the business office or physical therapy staff. It is the responsibility of the patient to come to all appointments. If you for some reason you need to cancel your scheduled appointment, please call the receptionist to cancel.

If you are a "no-show" for 3 consecutive appointments, you will be discharged as a patient. A new prescription from your physician will be required in order for you to resume physical therapy.

5. Progress Notes:

As a standard practice, physical therapists send progress notes to referring physicians. If your physician requests a progress note, you need to inform your physical therapist at least one (1) week prior to your scheduled follow-up office visit. With sufficient notice, your progress note can be sent to your doctor in a timely manner.

6. Insurance Verification, Collections and Billing:

It is your responsibility to know the nature and limits of your medical coverage. However, TSMC business office staff will collect insurance information and verify coverage with the insurance carrier. After insurance is verified, the staff will inform you of any financial responsibilities, such as co-pay, that may be due.

Insurance verification can be a time consuming process and is generally dictated by the availability and cooperativeness of your insurance company's employees. TSMC's business office staff will make every attempt to work with your insurance company in a professional and timely manner. If your insurance plan requires a referral from a primary physician, it is your responsibility to obtain the referral prior to your first visit. Without the primary physician referral, physical therapy cannot be initiated.

Billing for physical therapy services is prepared and sent by Tomball Regional Hospital's business office. Any concerns or issues with your billing statement need to be presented to the Hospital's business office, 281-351-1623.

7. When You Come for Therapy:

- a. **Sign-in:** When you arrive for therapy, please register your name on the sign in sheet located at the physical therapy receptionist desk. After signing in, take a seat and wait for a therapist or therapy tech to take you back to the treatment area.
- b. **Aquatic Therapy Sign-in:** Patients who are receiving aquatic therapy may go directly to the pool after registering. Once arriving at the pool, you must not enter the pool without the knowledge and consent of the aquatic therapist.
- c. **Clothing:** For your comfort and to aid the staff in caring for your injury, please wear or bring comfortable clothes that allow the staff access to the injury site. Staff recommendations for clothing: _____
- d. **Locker Rooms:** Locker rooms are available to patients. Locks are not provided by TSMC and the lockers are day use only. Patients who wish to use a locker are strongly encouraged to bring a lock to secure their belongings. TSMC is not responsible for personal items left in the lockers.
- e. **Cellular Phones:** Cell phones are to be turned off when you are in the physical therapy and exercise areas of TSMC. Cell phone use is permitted in the atrium and the reception area.

8. Transfer into Fitness/Recreation Program:

When you are ready to be discharged from physical therapy, you will be given the opportunity to join TSMC's Fitness / Recreation program. Former patients pay \$20.00/month for three months and the registration fee is waived. At the end of the three months, you can continue as a member at the established membership rates.

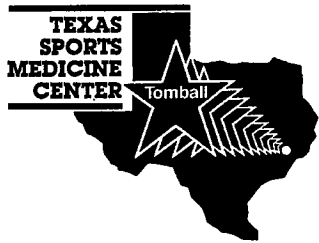
9. **OTHER:** _____

I attest that I understand all of the above policies and procedures. A TSMC Physical Therapy employee has explained those policies or procedures that I did not understand.

Patient Signature

Date

TSMC Staff Signature



PHYSICAL THERAPY

Policies and Procedures

Continued

SCHEDULING APPOINTMENT

Please schedule your appointment one week in advance. The physical therapist schedules can fill up quickly and in order to secure the best time that fits your personal needs, we encourage you plan ahead.

CANCELLATION & NO SHOWS

- In order to achieve the best results from the physical therapy process, all patients are encourage to avoid canceling or not showing up for therapy.
- Please call at least 24 hours in advance if you need to cancel an appointment.
- Patients who do not show-up and did not call in to cancel are susceptible to losing future appointment times.

INSURANCE & PAYMENTS

- Insurance for health coverage is very diverse and can be quite complicated. Never the less, it is the responsibility of the policyholder to know and understand the terms of his or her insurance. This includes knowing the financial terms of your policy as it relates to: maximum coverage, deductibles, co-pays and co-insurance payments
- TSMC's Business Office staff will verify insurance and report to our patients what we have learned from your carrier.
- Co-pays, co-insurance and deductibles are due at the time of services.

OFFICE RECORDS/CHART NOTES

- Patients' records are confidential and are protected by HIPPA laws.
- In order for Tomball Regional Hospital to process insurance claims and receive payment for services, patients must sign the assignment of benefits form

I acknowledge that the information provided to me has been read by me or explained to me by an employee of the Texas Sports Medicine Center.

Patient or "Legal Guardian" Signature

Date

TSMC Staff Signature

Date



PRESENT CONDITION QUESTIONNAIRE AND MEDICAL HISTORY

Patient Name: _____ Date: _____

Sex: M F Age: _____ Weight: _____

Occupation: _____ (If student, provide name of school: _____)

PRESENT CONDITION:

Present Problem: _____

Date of injury: _____ Referring Physician: _____

Date of next appointment with your MD: _____

Please describe how this injury occurred: _____

Were X-rays taken? Y or N Where: _____

Results: _____

Were X-rays taken? Y or N Where: _____

Results: _____

Was any other diagnostic testing done? Y or N Where: _____

Is this a recurring problem? Y or N Where: _____

How are you taking care of the problem(s) now? _____

What makes the problem(s) better? _____

What makes the problem(s) worse? _____

What are your goals for physical therapy? _____

HISTORY:

Do you have a history of:

- Diabetes Y or N
- Arthritis Y or N
- Cardiac Conditions Y or N
- Blood Pressure high/low Y or N
- Cancer Y or N
- Osteoporosis Y or N
- Seizures Y or N
- DVT (blood clot) Y or N
- Incontinence Y or N

Are you latex sensitive? Y or N

Are you pregnant? Y or N

MEDICATIONS:

Please list any known allergies to medications:

1. _____
2. _____
3. _____

Please list any current medications you are taking:

1. _____
2. _____
3. _____
4. _____

SURGERIES:

1. _____
2. _____
3. _____

Any other medical conditions we should know about? _____



PATIENT REGISTRATION

Patient Name: _____ Date ____ / ____ / ____

Address: _____ City: _____ ST: _____ Zip _____

H #: (____) ____ - ____ W#: (____) ____ - ____ C#: (____) ____ - ____

SS #: _____ - ____ - ____ Date of Birth: ____ / ____ / ____ AGE: _____

Marital Status (circle one): SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER

In Case of Emergency, Notify: _____ Relationship: _____

Address: _____ City: _____ ST: _____ Zip _____

H #: (____) ____ - ____ W#: (____) ____ - ____ C#: (____) ____ - ____

Has patient had P.T. before? ___ NO ___ YES When? _____ Where? _____

Present Injury: _____ Date of Injury: ____ / ____ / ____

Cause of Injury (circle one) Work Related / Vehicle Accident / Sports Injury / Other

Referring Physician: _____ Evening Phone #: (____) ____ - ____

Employer: _____ Phone #: (____) ____ - ____ Ext: _____

Address: _____ City: _____ ST: _____ Zip _____

Insurance Carrier: _____ Phone #: (____) ____ - ____ Ext: _____

Name of Insured: _____ SS #: _____ - ____ - ____

Insured's Date of Birth: ____ / ____ / ____ Group #: _____ Policy #: _____

Insured's Employer: _____ Phone #: (____) ____ - ____ Ext: _____

Address: _____ City: _____ ST: _____ Zip _____

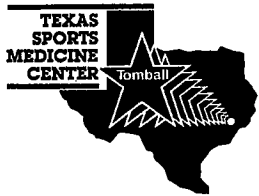
Insurance Carrier: _____ Phone #: (____) ____ - ____ Ext: _____

Name of Insured: _____ SS #: _____ - ____ - ____

Insured's Date of Birth: ____ / ____ / ____ Group #: _____ Policy #: _____

Insured's Employer: _____ Phone #: (____) ____ - ____ Ext: _____

Address: _____ City: _____ ST: _____ Zip _____



PATIENT INFORMATION Workers Compensation Form

Patient Name: _____ Date ____ / ____ / ____

Address: _____ City: _____ ST: _____ Zip _____

H #: (____) ____ - ____ W#: (____) ____ - ____ C#: (____) ____ - ____

SS #: ____ - ____ - ____ Date of Birth: ____ / ____ / ____ AGE: _____

Marital Status (circle one): SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER

In Case of Emergency, Notify: _____ Relationship: _____

Address: _____ City: _____ ST: _____ Zip _____

H #: (____) ____ - ____ W#: (____) ____ - ____ C#: (____) ____ - ____

Has patient had P.T. before? ___ NO ___ YES When? _____ Where? _____

Referring Physician: _____ Evening Phone #: (____) ____ - ____

Present Injury: _____ Date of Injury: ____ / ____ / ____

Employer: _____ Phone #: (____) ____ - ____ Ext: _____

Address: _____ City: _____ ST: _____ Zip _____

W/C Insurance Carrier: _____

Adjuster: _____ Phone #: (____) ____ - ____ Ext: _____

Claim Number: _____

MAIL CLAIMS TO:

AUTHORIZATIONS:

DATE:	AGENT:	# APPROVED:	AUTH NUMBER:	INITIAL:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HAVE BENEFITS BEEN EXPLAINED TO PATIENT? ___ NO ___ YES DATE: _____

PATIENT'S INITIALS _____ TSMC STAFF INITIALS _____