SMART INSTITUTE

3600 W. 7th St.~Ft. Worth TX 76107

817.377.3422

~Patient Information~

Last Name: ________________________ First: ________________________ M. I.: _______

Address: __________________________ City: _____________State: _____ Zip: ______________

Phone: __________________ Date of Birth: ______________

Marital Status: ☐S ☐M ☐D ☐W ☐Sep. SSN: _______________ Driver's License: __________

Place of Employment: __________________________________ Work Phone: _____________________

Employer's Address: ________________________ City: _____________State: _____ Zip: ___________

Emergency Contact: _________________________ Relationship: ____________ Phone: ______________

Address: _________________________________ City: _____________State: _____ Zip: ___________

~Insurance Information~

Responsible Party: _________________________ Relationship: ____________ Phone: ______________

Place of Employment: _________________________________ Work Phone: _____________________

Date of Birth: _____________________________ SSN: ________________________

Address: _________________________________ City: _____________ State: _____ Zip: ___________

Primary Insurance: ___________________________ Plan/Group No.: _____________________________

Policy No.: _________________________ Effective Date: ______________ Phone: __________________

Secondary Insurance: _________________________ Plan / Group No.: ___________________________

Policy No.: ________________________ Effective Date: ______________ Phone: ___________________

_________**Please be aware that we will verify your insurance benefits with your insurance carrier. However, we cannot be held responsible for the information that your insurance carrier provides to us. If you have any questions regarding your insurance benefits, you are strongly encouraged to contact your carrier directly at the number on the back of your insurance card. If you should have any questions regarding your bill for outpatient therapy at the SMART Institute/Cross Timbers please contact our facility at (817) 377-3422 to be directed to the billing company. If you should have any questions or concerns regarding your medical care please talk to your therapist.**

We appreciate the opportunity to serve you and welcome any suggestions or comments that you may have. Thank you for choosing the SMART Institute/Cross Timbers for your rehabilitation needs!

Patient Signature: ___________________________________ Date: ____________________________

~Medical History~

Patient Name: ______________________ Age: ________ Sex: ☐M ☐F

Referring Physician: ____

What is the main reason for your visit to our clinic? ______________________________

Caused by an accident? ☐ Yes ☐ No Workers Comp? ☐ Yes ☐ No

When did your symptoms begin? (Approximate Month &Year)______________________

Have you had Home Health within the year? ____________ If so Where? ____________

Have you had Physical or Occupational Therapy within the year? ___________ If so where?

____

Are you allergic to any medications? ☐ Yes ☐ No

If Yes, what medications? ____

____

Please list all medications you are currently taking:

____

____

Do you have any of the following medical conditions?

Heart Problems	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

Approximate Date(s): ______________

Other: ____

____

~SMART Institute Therapy Policy~

If you arrive early to your appointment, it is up to our therapists to see you early. If you are more than 15 minutes late for your appointment, it is up to our therapists to see you that day depending on scheduling. If you know that you are going to be late for your appointment, please contact Jennifer as soon as possible so that we can make accommodations or re-schedule your appointment. **Please keep in mind that Physical and Occupational Therapy are time-based services. Patients are here for a specific amount of time each visit therefore the only times we can see you late or early is if there are cancellations. Initial_______**

All absences are documented and reported to those involved in your care. This could include your doctor, insurance carrier, and or insurance adjuster. **Initial_______**

If you know you are going to miss an appointment, please call us 24 hours prior to your appointment time so that we can schedule someone else in that available time and re-schedule you appointment.
If you cancel or no-show for three (3) or more consecutive appointments, we will ask that you return to your physician for re-evaluation and a new prescription for continued treatment, if necessary. **Initial_______**

Please perform your "Home Exercise" program assignments as requested by your therapists and come prepared for therapy (i.e. loose fitting clothing).

Therapy prescriptions written by your physician expire every thirty (30) days. You will be re-evaluated by your therapists to determine if further treatment is necessary. We will contact your physician with recommendations.

Patient Signature: ____ Date:________________________

~Authorizations, Consents and Agreements~

Authorizations: I hereby authorize you to pay direct to SMART and any indemnity which may become due to me by virtue of services received at The Smart Institute by myself or my dependent.

INITIAL: ______________

Consent to Treatment: As a patient at SMART, I consent to care and treatment only after my PT and or OT explains the recommended treatment in terms I understand. I understand that while a patient at SMART, I will be under the care of my attending physician

INITIAL: ______________

Financial Agreement: I hereby guarantee payment for services rendered at SMART. I understand that the patient and other responsible parties will be held responsible for court cost, legal fees or agency fees, which may be incurred in the collection of the account.

INITIAL: ______________

Assignment of Benefits: I hereby authorize all insurance companies to pay direct SMART who rendered care any benefits and fees under my insurance policy or policies. I understand that this order does not relieve me of my obligation to pay the account. Also, any balance that is not covered or paid by the insurance company is my responsibility.

INITIAL: ______________

Medicare Beneficiaries Only: I certify that the information given in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made. Also, assignment of payment for the unpaid charges. . I understand that I am responsible for health insurance deductibles and coinsurance.

INITIAL: ______________

Teaching Facility: I understand that SMART is affiliated with PT and OT schools, and other academic programs and students may be involved with my care.

INITIAL: ______________

I have read the Authorizations, Consents and Agreements, and I accept the terms as described above.

______________________________ ______________________________

Signature of Patient/Responsible Party (Relationship) Print Patient Name

______________________________ ______________________________

Date Witness Signature

~SMART HIPAA Compliance Patient Consent Form~

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patients rights sections describing your rights under the law. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA law allows for the use of the information for treatment, payment of all healthcare operations.

By signing this form, you consent to disclose your protected healthcare information. You have the right to revoke this consent in writing if need be.

By signing this form, I understand that:

~Protected health information may be disclosed or used for treatment and payment.

Signature:___________________________ Date:_________

This consent was signed by:________________________________

(Please Print)