WELCOME PACKET

Dear Patient:

Thank you for choosing ***Avila Physical Therapy*** (APT) as your new home for all of your physical therapy needs. Our staff is delighted to have you join our facility, and our goal is to provide you with a premium level of care and the highest quality experience. If you have any questions or concerns at any time during your plan of care, please feel free to contact our office or email us directly.

Thank you again for choosing APT. We look forward to treating you and helping you achieve your individual goals. Our hope is to exceed all of your expectations!

Kind regards,

Dr. Anthony Avila, PT, DPT
Owner

CORPUS CHRISTI CLINIC
1726 Braeswood Drive
Corpus Christi, TX 78412

KINGSVILLE CLINIC
1114 N. 14th Street
Kingsville, TX 78363

P: (361) 500 - 6686 **F**: (361) 299 - 5882 **E-mail**: anthony@avilaphysicaltherapy.com

Patient Information

Full Name: ______________________________ DOB: _____ /_____ /________

SSN: ______-____-________

☐ New Patient

☐ Previous Patient If so, any changes in address or contact information? Y / N

(Please update any changes below.)

Street Address: __________________________ Home Phone: ______________

City/State/Zip Code: ______________________ Cell Phone: _______________

E-mail: _______________________________

Employer: ______________________________ Work Phone: ______________

Marital Status: *Single* *Married* *Divorced* *Widowed* *Life Partner*

Sex (at birth): M / F

Are you currently pregnant or planning to become pregnant? Y / N

If yes, how many weeks? _____________

Are you currently undergoing any treatments for cancer? Y / N

Emergency Contact: ________________________ Contact #:_______________

Relation: __________________________

Primary Care Physician or Referring Physician: ___________________________

Practice/Clinic Name: ______________________ Contact #: _______________

Insurance Information

Primary Insurance: ____________________ Policy Holder: ________________

ID #: ________________ Group #: _______________ Effective Date: ________

Secondary Insurance: __________________ Policy Holder: ________________

ID #: ________________ Group #: _______________ Effective Date: ________

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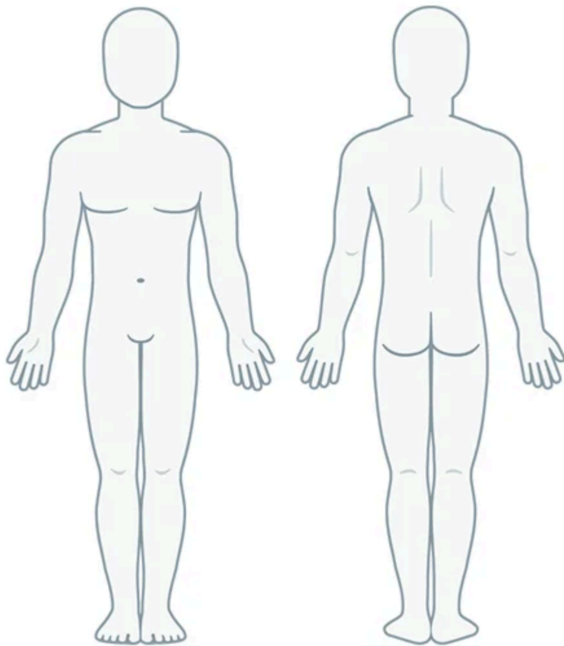
CURRENT CONDITION

Reason for today's visit? *(Please be specific).* ____

Please mark the area(s) of concern with an ***X***.



Onset Date: ______ /______ /_________

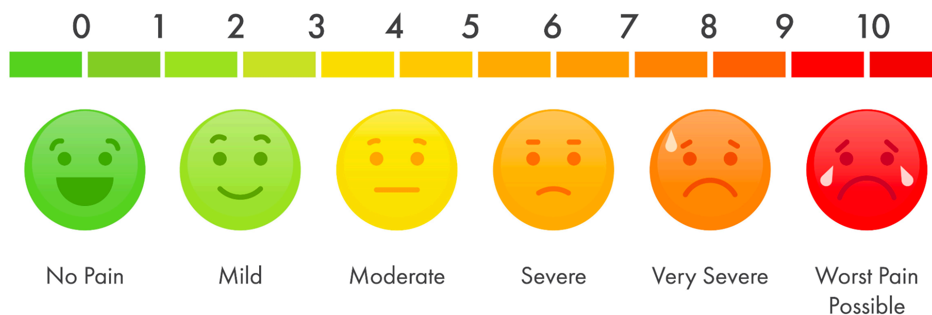
Surgery Date: ______ /______ /_________

What type of pain are you experiencing?

- ☐ Burning
- ☐ Sharp
- ☐ Aching
- ☐ Throbbing
- ☐ Shooting
- ☐ Dull
- ☐ Numbness
- ☐ Tingling
- ☐ Dizziness

Please rate the severity of your pain on a scale of 0 to 10. *(Please circle one).*

PAIN SCALE



Have you had this pain in the past? Y / N

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How has your current condition been treated? *(if any).*

- ☐ Medications
- ☐ Injections
- ☐ Surgery
- ☐ Physical Therapy
- ☐ Chiropractic Care
- ☐ Massage Therapy
- ☐ Acupuncture

How did you hear about us?

- ☐ Doctor's Referral
- ☐ Friend or Family *(Provide name.)* ______________________________
- ☐ Facebook/Instagram
- ☐ Google Search
- ☐ Other: ________________________

HEALTH HISTORY

Please list any surgeries, falls, fractures or broken bones, head injuries, or other illnesses you have had?

Please list all medications you are taking. *(Prescribed or over the counter, supplements etc.)*

Have you ever suffered from or have been told that you have any of the following?:

- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Headaches
- ☐ Stroke
- ☐ Liver Problems
- ☐ Thyroid Problems
- ☐ Blood Disorders
- ☐ Diabetes
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Circulatory or Vascular Problems
- ☐ Broken Bones
- ☐ Chronic Pain
- ☐ Ulcers or Stomach Problems
- ☐ Other Orthopedic Conditions

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PAYMENT POLICY

INSURANCE: We participate with most major medical insurance plans. If you are not insured by a plan that we participate with, payment in full is expected at each visit at the time of service. **If your insurance coverage changes, please notify us before your next visit** so that we may make the appropriate changes to help you receive your maximum benefits. **You are fully responsible for understanding your insurance policy and coverage.**

REFERRALS: If your insurance requires a referral for a specialist visit, it is your responsibility to provide us with the referral dated the day of your first visit with your Primary Care Physician (PCP). **We are not able to request a referral from your PCP or insurance**. If you do not have the referral at the time of your initial evaluation, **your appointment will be rescheduled until we have obtained the referral**. If you are unsure if your insurance requires this or you have any other questions concerning the process, we suggest you contact your insurance company. Knowing your insurance benefits is your full responsibility.

CO-PAYMENTS & DEDUCTIBLES: All co-pays and deductibles **must be paid at the time of service**. This arrangement is part of your contract with your insurance company. Failure on our part to collect payments from our patients can be considered fraud.

CLAIMS SUBMISSIONS: We will submit your claims and assist you in any way we responsibly can to help get your claim paid. If your insurance company needs you to supply certain information directly, it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. **If your insurance company does not submit payment within 60 days, the balance will automatically be billed to you**. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

COLLECTIONS: Unpaid balances will be sent to collections. If your balance is sent to collections, you will be responsible for 33% of your balance in addition to the original amount sent to collections.

ASSIGNMENT OF BENEFITS AUTHORIZATION

I certify that, I or my dependent(s), have insurance coverage with ____ (insurance company). I assign directly to Avila Physical Therapy, LLC all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance****. I authorize the use of my signature on all insurance submissions. I also authorize release of my medical information relevant to these services when required by Health Care Financing Administration (HCFA), its agents, or insurance carriers for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable to related services.*

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given *Avila Physical Therapy's* Notice of Privacy Practices. I understand that if I have any questions or complaints, I may contact the facility.

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NO-SHOW, CANCELLATION & RESCHEDULING POLICY

Patients will be **charged a $50 fee for appointments canceled within the 24 hours preceding their scheduled appointment time**. This means, if the patient calls the same day of his/her appointment to cancel or reschedule their visit, a $50 will be enforced. This fee may be waived in the case of unexpected illness by providing our office with a doctor's note or receipt from a pharmacy, and/or on a case-by-case basis in the event of a personal emergency.

For any patient that **shows up more than 15 minutes late to his/her scheduled appointment time, the appointment will need to be rescheduled and the $50 fee will also be enforced**. We need at least 24 hours' notice to be able to fill any appointment time slots due to patient cancellations. This charge is your financial responsibility and will be collected on your next visit.

Following a total of **3 same-day cancellations**, the patient will be removed from the schedule and placed on a same-day scheduling list, forfeiting their future appointment times.

There is a **$50 fee for no-show or missed appointments**. After **2 missed appointments**, the patient will be **immediately removed from the schedule and will be discharged** from the clinic. Your physician will be notified at that time.

This cancellation policy is in place out of the respect of our therapists, as well as additional patients. This advanced notice allows ample time and opportunity to fill any open appointment time that is needed to provide treatment to another person. Please consult our front office if you have any questions regarding our policy.

I have read the above cancellation policy and I understand the information provided. I, therefore, authorize this clinic to enforce the cancellation fee, if applicable to me.

Patient's Signature: ❌___________________________________ Date: ______________________

APPOINTMENT REMINDERS

Appointment reminders will be sent via text message or E-mail 2 days prior to your appointment. If the patient does not have access to an E-email address, we will not be able to send out a reminder. If you would prefer a voicemail reminder instead, please notify our front office with your request.

CONSENT TO TREAT

I have been informed of the nature of my condition and/or disorder(s) and the purpose of physical therapy interventions proposed for treatment. I have also been informed of the possible consequences and risks inherent to such treatment. The availability of alternative treatment options have been explained to me and I have the right to seek out care elsewhere if I should decide to discontinue with PT services. I have also been advised of the possible consequences should I decline to receive care. I understand that there is no guarantee or warranty for any specific result or outcome of my current condition. The welcome/information packet and all additional data from *Avila Physical Therapy* may be used for health, information, and billing purposes interchangeably between various office locations, if necessary.

I have read the above statements and I understand the information provided. I, therefore, authorize this clinic to proceed with physical therapy care and treatment.

Patient's Signature: ❌ ________________________________ Date: ____________________

Please complete the following if the patient is *a minor OR unable to consent.*

Name of Person legally authorized to sign for this patient: ____________________________

Relationship to Patient: _____________________________

Signature of Authorized Person: ❌ _______________________ Date: ___________________

Protected Health Information (PHI) Release Authorization

Persons who are involved in your care (spouse, children, friends, etc.) may inquire about your treatment, appointments, billing, and medical records. Please let us know below whom we may share your PHI with:

*Leave blank if none

______________________ ___________________ ___________________

Name Phone Number Relationship

______________________ ___________________ ___________________

Name Phone Number Relationship

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