TRIANGLE THERAPEUTICS | OUTPATIENT PHYSICAL THERAPY

# PATIENT INFORMATION FORM

Last Name: _____ First: _____ M.I.: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell Phone #: _____ SS#: _____

Date of Birth: _____ Sex: ❑ M ❑ F Driver's License #: _____

Email Address: _____ ❑ *By checking this box, you are authorizing **Triangle Therapeutics** to send all account and invoice information via email.*

**How did you hear about us:** _____

Ethnicity: ❑ White ❑ Black ❑ Asian ❑ Hispanic ❑ Arabic ❑ Alaskan ❑ Am. Ind. ❑ Other: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Other Spouse's Name: _____

Emergency Contact: Name: _____ Phone No.: _____

**WORK / SCHOOL INFORMATION**

**STATUS:**

❑ Working full-time out of home ❑ Part-time out-of home ❑ Full time from home ❑ Part-time from home

❑ Working w/ modification because of current injury ❑ Not working because of current injury ❑ Homemaker

❑ Student ❑ Retired ❑ Unemployed

Occupation (if applicable): _____

Employer's Name: _____ Phone No.: _____

Employer's Address: _____

Student ❑ Yes ❑ No If so, please list school: _____

**CONSENT:** I consent to the following at TTI (Triangle Therapeutics Inc.) Please Initial

_____ I voluntarily consent to outpatient physical therapy services at TTI.

_____ I am responsible for my PERSONAL ITEMS & TTI is not responsible for any items that are lost, stolen or damaged.

_____ I have received & understood the No Show & Cancellation Policy, Financial Responsibility Form and Patient Guidelines & Responsibilities.

_____ I understand my HIPAA & Privacy Rights and I can request a copy of the HIPAA Privacy Notice at any time from TTI.

_____ I grant permission to TTI to obtain information from health care providers, payor source or employer &/or school as it applies to my treatment. I also grant permission to TTI to release my medical information to healthcare providers and payor sources (insurance, third party, lawyer) for the purpose of continuing care, reimbursement or legal reasons.

_____ I grant permission for TTI to take PHOTOGRAPHS/VIDEOS of myself during my stay which may be used for advertising, marketing & promotion.

**I certify that the above information are true and correct to the best of my knowledge.**

*You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.*

**I/We have read this disclosure and agree that Triangle Therapeutics, Inc. or any third party agency acting on your behalf may contact me/us as described above.**

Patient Signature (or Legal Guardian if Patient is a Minor): _____ Date: _____

5957 9th Ave.
Port Arthur, Texas 77642
PH: 409.982.8878 FX: 409.982.5119

2990 Laurel Ave.
Beaumont, Texas 77702
PH: 409.861.1009 FX: 409.861.4009

www.triangletherapeutics.com

PATIENT NAME: _____

TRIANGLE THERAPEUTICS | OUTPATIENT PHYSICAL THERAPY

| | |
|---|---|
| **PRIMARY DR:** | |
| **NEUROLOGIST/NEUROSURGEON:** | **ORTHOPEDIC DR:** |
| **ARTHRITIS DR:** | **OTHER:** |

Some illnesses and conditions are genetically transferred. It is useful for us to know what conditions you and your family members have or had in the past.

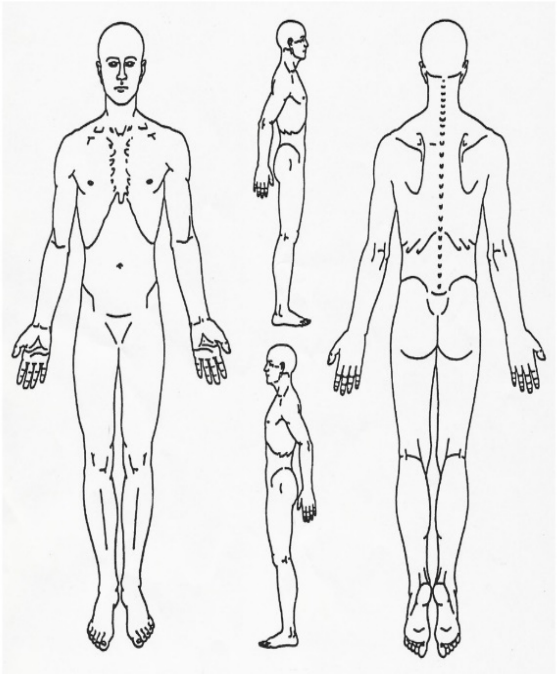
**CIRCLE THE CONDITIONS THAT ARE APPLICABLE TO YOU AND INDICATE HOW LONG YOU HAVE HAD IT**:

| CONDITION | WHEN | CONDITION | WHEN |
|---|---|---|---|
| ARTHRITIS | | PACEMAKER | |
| FRACTURES | | METAL IMPLANTS | |
| HEADACHES | | OSTEOPOROSIS | |
| HYPERTENSION | | TUBERCULOSIS | |
| FREQUENT FALLS | | HEPATITIS | |
| CANCER | | HEART PROBLEMS | |
| DIABETES | | DIFFICULTY WALKING | |
| **PREVIOUS SURGERIES:** | | | |
| **CURRENT MEDICATIONS:** | | | |
| **ALLERGIES/SENSITIVITY:** | | | |

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

| | | | |
|---|---|---|---|
| A = Ache | B = Burning | R = Radiating Pain | D = Dull Pain |
| N = Numbness | S = Stabbing | P = Pins & Needles | O = Other |



**Describe your pain (circle):**

| | |
|---|---|
| Constant | Steady |
| On and off | Short-lived |

**OTHER DESCRIPTION:** _____

**What helps ease your pain?** _____

**What increases your pain?** _____

**On a scale of 0-10 (0-best, 10-worst), how would you rate your pain levels in regard to the body part we are treating you for**: Worst pain: ___ Current pain: ____ Least pain: ___

**By signing below, I attest that the above information is true to the best of my knowledge.**

**PATIENT SIGNATURE:** _____ **DATE:** _____

TRIANGLE THERAPEUTICS | OUTPATIENT PHYSICAL THERAPY

Was the prescribed injury that you are seeking treatment for, sustained due to a motor vehicle accident? If so, do you plan to use your Personal Injury Protection (PIP) insurance?_____
_____

Was the prescribed injury that you are seeking treatment for, sustained due to a work-related injury? Have you filed a Workers Compensation Claim?_____
_____

Are you currently in a Skilled Nursing Facility? Within the past year were you in a Skilled Nursing Facility? If so please list the facility name and phone number. _____
_____

**THE TWO QUESTIONS BELOW PERTAIN TO MEDICARE PATIENTS ONLY**

Do you have any provider or nurse come to your home for any reason? If so, list the company name and telephone number, as well as reason for them coming to you home. _____
_____

Within the past year has a nurse or provider come to your home for any reason? If so, list the company name and telephone number, as well as reason for them coming to your home. _____
_____

**DISCLAIMER:** If you chose to file an injury sustained by a motor vehicle accident or work-related injury on your private health insurance, please understand any of the following instances can occur: A.) Your private health insurance may deny to pay your claims, B.) Your private health insurance can recoup payment after previously paying a processed claims, C.) You may exhaust or max out your (PIP) insurance. In these instances any unpaid or recouped balances will be transferred to you and become your responsibility to pay the portion allowed by your insurance to Triangle Therapeutics.

MEDICARE WILL NOT ALLOW YOU TO HAVE PHYSICAL THERAPY AND TO HAVE SOMEONE COME TO YOUR HOME (FOR ANY REASON, NOT JUST THERAPY, AT ANY TIME). BY SIGNING THIS I AGREE TO NOTIFY TRIANGLE THERAPEUTICS IF I BEGIN TO HAVE A NURSE OR PROVIDER COME TO MY HOME. IF MEDICARE DENIES ANY CLAIMS FOR THE REASONING ABOVE, I AGREE TO PAY THE PORTION ALLOWED TO TRIANGLE THERAPEUTICS BY MEDICARE.

_____ _____

Signature Date