SNOWDEN ORTHOPEDIC & OCCUPATIONAL REHABILITATION
12758 CIMARRON PATH, STE. 126
SAN ANTONIO, TEXAS 78249
Ph.#: (210) 615-8844 Fax #: (210) 615-6959

ReDoc ☐
MediSoft ☐

Name: _____ **SS#:** ___-___-___ **DL#:** _____
Date Of Birth: ____/____/____ **Age:** _____ **Sex: Female** _____ **Male** _____
POBOX/Street Address: _____ **Phone #:** _____
City/ State/ Zip Code: _____ **2nd Phone #:** _____
Employer: _____ **Phone #:** _____
Email Address: _____
Employer Address: _____ **City/State/Zip Code:** _____
Emergency Contact: _____ **Relationship:** _____ **Phone#:** _____

****

Who may we thank for this referral? _____
Referring Physician: _____ **Address:** _____
Telephone: _____ **Fax:** _____
Type of Injury/ List areas involved: _____

****

MEDICAL HISTORY

Date of Injury: ____/____/____**Auto?** _____ **On the Job?** _____ **Other:** _____
Surgical Date/ Type: _____ **First date of loss time from work:** _____
Have you had testing done for this injury: _____ **If yes, please circle:**
XRay Myelogram MRI Catscan EMG Neurological Bone Scan Other_____
Do you have any other health conditions or medical history that we should know about? Explain_____
_____
_____
Diabetes:_____**Asthma/Inhaler:**_____
Epilepsy: _____ **Pacemaker:**_____
Heart Disease:_____ **Defibrillator:**_____
Cancer/ Tumor: _____ **Skin Rash/Condition:**_____
High Blood Pressure: _____ **Stroke:**_____
Past Surgeries:_____
_____
Please list any medications you are allergic to: _____
Are you currently on an exercise program? Type and Frequency: _____
Prescribed by Doctor Yes No

AUTHORIZATION: I authorize Snowden Rehabilitation to release information acquired in the course of my examination or treatment to my referring or treating physician, employer, insurance carrier, worker's compensation carrier or legal representative. I also understand that I am FINANCIALLY RESPONSIBLE for all charges incurred from my treatment at Snowden Rehabilitation unless covered by my worker's compensation insurance carrier. This authorization will be for an indefinite period unless I specify an end date for the authorization.

Appointments: If unable to keep appointments, please give 24 hours' notice. ***There will be a $25.00 fee assessed to the patient when they fail to cancel.***

Patient/Client Signature: _____ **Date:** _____

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INSURANCE DISCLOSURE

I, _____, DO / DO NOT have any additional Health
Patient Name *circle one*

Insurance other than _____, which I have provided.
Insurance Name

If at any time your insurance changes or is terminated please inform the receptionist of this change as soon as possible.

FAILURE TO DISCLOSE ANY ADDITONAL HEALTH INSURANCE YOU MAY HAVE CAN RESULT IN UN-PAID CLAIMS. THEREFORE, LEAVING YOU FULLY RESPONSIBLE FOR ALL UN-PAID PHYSCIAL THERAPY BILLS.

_____ _____
Patient Signature Date

CANCELLATION POLICY

Your appointment time is valuable and has been reserved especially for ***YOU***.

If it is necessary to reschedule your appointment, please provide us with 24 hours notice. Otherwise, a charge of $25 will be incurred and due **BEFORE** next scheduled appointment.

_____ _____
Patient Signature Date

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Notice of Privacy Practices

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How medical information about you may be used and disclosed and how you can access this information

- We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
- We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.
- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
- We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.
- You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical Information, please contact:

ANNE ARMSTRONG, CLINIC ADMINISTRATOR OF OUR OFFICE AT 210-615-8844

PATIENT SIGNATURE: _____ DATE: _____