OAKBEND
MEDICAL CENTER

## *Patient Information Sheet*

*OakBend Therapy Jackson Street*
*281-341-2874*

Thank you for choosing to have your physical therapy services with ***OakBend Medical Center.***

OakBend Medical Center will gladly file a claim for your services with your insurance company. We must rely on the benefit information provided by your insurance to give you an ***estimate*** of your out-of-pocket expense. Your out-of-pocket amount may change once the insurance actually processes our claim. Your final out-of-pocket expense will be shown on the Explanation of Benefits you will receive from your insurance.
If you have over payed you will be issued a refund.

If your insurance has terminated, or your insurance has changed and you fail to notify us, you may be responsible for the entirety of the bill.
It is **your responsibility** to notify us of any insurance changes.

**Co-payment/co-insurance is due at the time of service.** We accept all major credit cards, cash, and checks.

If you have any questions regarding your claim or patient balance, please call OakBend's Customer Service Representatives at 281-341-4816 or 2847.

Thank you again for choosing to have your services with us.

***OakBend Medical Center***
1705 Jackson
Richmond, TX 77469
281-341-3000

_____ _____

Patient Signature Date

# OakBend Therapy Services at OakBend Medical Center No Show/Cancellation Policy

OakBend Therapy Services at OakBend Medical Center strives to provide each and every patient with personalized care and attention throughout their scheduled appointment time. In order to maintain this high level of care, it is very important that all patients attend their scheduled appointment time. If an appointment is scheduled but not attended, it takes a valuable appointment time away from other patients who have made it a priority to work towards their physical therapy goals.

"No Show" is missing a scheduled physical therapy appointment without a call prior to that appointment to inform OakBend Therapy Services. A "cancellation" is canceling a scheduled physical therapy appointment without giving 24 hours' notice. A "reschedule" is calling 24 hours prior to a scheduled physical therapy appointment to change that appointment to a different time or day because of a conflict.

_____ **If a patient arrives more than 15 minutes late for their scheduled appointment, they may be asked to wait until the physical therapy staff can accommodate their late arrival or may be asked to reschedule their appointment.**

_____ **If a patient "No Show" for more than one appointment, they will be seen when the physical therapy staff can accommodate their treatment without affecting other patient's quality of care.**

_____ **If a patient "Cancels" any three appointments without giving 24 hours' notice to our staff, they will be seen when the physical therapy staff can accommodate their treatment without affecting other patient's quality of care.**

_____ **After any three "No Shows or Cancellations" Rehabilitation Services at OakBend Medical Center reserves the right to discharge the patient from physical therapy. Our staff will inform the referring physician of the patient's non-compliance with attending their prescribed physical therapy. The patient must obtain a new prescription for physical therapy from their physician before being able to return.**

We understand true medical emergencies do occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

***I have read and understand OakBend Therapy Services at Oakbend Medical Center's No Show, Cancellation, and Rescheduling Policies and Procedures.***

***Signature:***_____ ***Date:***_____

## Outpatient Medical History / Subjective Information  Date: / /

**Name:** _____ **Birthdate:** _____ **Age:** _____ **Sex:** M F

**Home Phone #:** (_____) _____ **Cell Phone #:** _____

**Diagnosis:** _____

**Primary Physician:** _____ **Primary Language:** _____

**Preferred Learning Style:** (please circle) Reading Hearing Seeing Doing Other: _____

**Who other than the patient will be involved with the rehabilitation and education process?** _____

**Are you currently receiving Home Health Services?** Yes No (Please circle one)

**How did you hear about Oakbend Rehab Services?** _____

### Medical History (Please check all that apply)

| | | | |
|---|---|---|---|
| ☐ Heart Disease | ☐ Diabetes | ☐ High Blood Pressure | ☐ Pacemaker |
| ☐ Cancer | ☐ Epilepsy | ☐ HIV/AIDS | ☐ Arthritis |
| ☐ Hearing/ Visual Impaired | ☐ Stroke | ☐ Asthma | ☐ Latex Allergy |
| ☐ Osteoporosis | ☐ Hepatitis | ☐ Kidney/ Bladder Control | ☐ Dizziness |

**If you are female, is there any possibility that you are pregnant?** Yes No N/A

### TB Screening

**Recent history of persistent cough?** Yes No

**Recent history of persistent fever?** Yes No

**Recent history of night sweats?** Yes No

**Recent history of unexplained weight loss?** Yes No

**History of treatment or exposure to TB?** Yes No

**Please list all medications currently taking:** _____

_____

**Please list all operations you have had:** _____

_____

**Please list any allergies to drugs, food, or environment:** _____

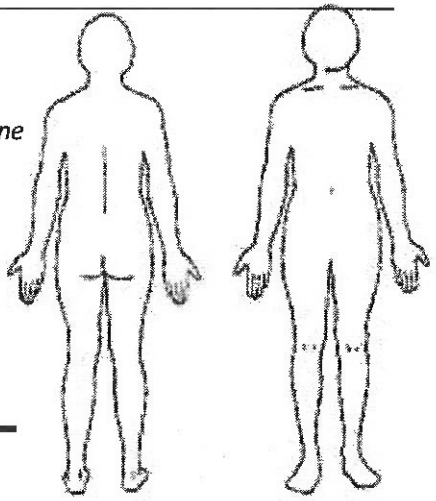
### Injury/Problem Information

**How and when did the injury or problem occur?** _____

_____

**Have you had any prior/previous treatment for this injury?** X-RAY MRI CAT SCAN Physical Therapy Injections Chiropractic Services Massage Therapy Acupuncture Other: _____

**Please indicate on the image below where the pain or problem is located:**



**Is your pain:** Constant Intermittent (Please circle one)

**Please rate your pain using a 0 – 10 scale:**

*0 = no pain at all, 5 = pain interferes with daily tasks 10 = worst pain you can imagine*

**Worst pain since onset?** _____ **Best pain since onset?** _____

**Todays Pain?** _____

**Does the pain wake you up at night?** Yes No

**What position helps you to sleep?** _____

**What makes your pain/problem better?** _____

_____

**What makes your pain worse?** _____

**Are you using heat?** Yes No **Are you using cold or ice?** Yes No

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**Physical Therapist's Comments:** _____

_____

_____

_____

## Physical Therapy Goals and Expectations:

**What problems are you experiencing because of your diagnosis or injury?**

1)_____

2)_____

3)_____

**What are your goals for Physical Therapy?**

1)_____

2)_____

3)_____

**What do you hope to learn from Physical Therapy?**

1)_____

2)_____

3)_____

## Employment History:

**Are you currently working?** Yes No **If no, how many days have you missed?** _____

**Are your work duties:** Full Time Light Duty Special Restrictions **How many hours a week do you work?**_____

**Who is your employer?**_____

**What kind of work do you do?** _____

**What work duties have been most affected by your problem?** _____

## Activity and Exercise History:

**Are you exercising at home?** Yes No **If yes, what type?** _____

**How many days a week do you exercise or stay active?** _____

**Have you participated in a prolonged exercise program in the past?** Yes No **If yes, what type and how long?** _____

_____

***To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at OakBend Medical Center. I have received a copy of The Patient/Client Rights and Responsibilities Information Sheet.***

Patient Signature: _____

Date:_____

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**Therapists Section:**

**Identified needs for community resources:** Child/Youth Senior Adult Support Groups

**Plans to address special learning factors/barriers (as identified):** _____

**Therapist Signature:**_____ **Date:** _____

# Medication List
## OakBend Out-Patient Physical Therapy

Name: _____

Date: _____

Pharmacy: _____

| Medication Name | Reason Taken | Dosage | Special Instructions |
|---|---|---|---|
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