

Patient Registration Form – Commercial

Patient Name:		Preferred:	
Address, City, State, Zip:			
DOB:		Social Security #:	
Email Address:			
Home Phone:		Appointment Reminder Method	
Cell Phone:		☐ Home Phone ☐ Cell Phone	
Work Phone:		☐ Work Phone ☐ Email	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Partner's Name:	
Financial Responsibility: ☐ Self ☐ Other, Please List:			
2nd Contact Name/Address:			
2nd Contact Phone:		Relation:	
General Physician:		Referred By:	
Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:			
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:			
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No			
If yes, Home Healthcare Provider:			

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible for providing their most current insurance information.			
Primary Insurance:		Secondary Insurance:	
Group #	Policy #	Group #	Policy #
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at Texas Physical Therapy Specialists (TexPTS) and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to TexPTS. I authorize the filing of claims to my insurance plan and authorize TexPTS to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believe were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

Signature of Patient/Guardian

Date

Print Name

Relationship to the Patient

Patient name:
DOB:
Authorization for Communication

By providing my above contact information and signing below, I consent and authorize TexPTS and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, (if opted in) and electronic mail to (1) provide messages (including prerecorded messages or text messages, (if opted in)) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message, (if opted in) that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting TexPTS or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify TexPTS immediately of any change in telephone number or email address.

Please check the box below to opt in to receive messaging.

- ☐ **I consent** to receiving text messages about care, appointment reminders, and important health reminders from TexPTS at the phone number I provided. I acknowledge that my consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. You can reply HELP for support or STOP to opt out of receiving messages. To learn more about how we handle your data please view our privacy policy [here](https://texpts.com/wp-content/uploads/sites/31/2026/04/TexPTS-Website-Privacy-Policy-Terms-11-2025.pdf).

<https://texpts.com/wp-content/uploads/sites/31/2026/04/TexPTS-Website-Privacy-Policy-Terms-11-2025.pdf>

- ☐ **I do not** consent to receiving text messages.

Patient/Guardian Signature:

Date:

Release of Information

I hereby authorized TexPTS to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
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Name (print)	Relationship	Phone number
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Name (print)	Relationship	Phone number
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Patient/Guardian Signature:

Date:

Financial Policy
Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature:

Date:

Patient name:**DOB:****Cancellation/No Show Policy and Fee Acknowledgement**

It is the policy of TexPTS to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of \$50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

Patient/Guardian Signature:

Date:

Physical Therapy Medical Screening Questionnaire

Name: _____

DOB: ____/____/____ **Date:** ____/____/____

Sex: M F **Age:** ____ **Ht:** ____ **Wt:** ____

Smoker: Y N **Possibly Pregnant?** Y N

Occupation: _____

Briefly describe your regular exercise routine:

Past Surgical History (please include dates if known):

Current Medications (please list or provide a list to photocopy):

Recent diagnostic imaging (MRI, XR, CT) or blood work for current symptoms: _____

PAST MEDICAL HISTORY: Please 1) Put a line through any condition you have **NEVER** had, and 2) Circle each condition you currently have **OR** ever had in the past.

Cancer Diabetes I or II Stroke Blood Clot Pacemaker Depression Seizures Asthma

High Blood Pressure Heart Disease Liver Disease Kidney Disease Lung Disease Fibromyalgia

Osteoporosis Osteoarthritis Rheumatoid Arthritis Ulcers

Allergies: _____ **Other(s):** _____

Recent illness? (explain): _____

How many times have you fallen in the past 12 months? _____ **Did it result in an injury? (Y/N)** _____

Recently I have been experiencing (please circle all that apply, AND put a line through any that do not):

Fever/Chills/Sweats Unexplained weight loss Difficulty swallowing Vision changes

Increased pain at night/rest Difficulty speaking Changes in appetite Poor balance/Falls

Numbness or Tingling Nausea/Vomiting Unusual pain with menstruation Shortness of breath

Dizziness Pain with meals Chest PAIN Change in (Bowel) or (Bladder) control/habits/appearance

CURRENT SYMPTOMS:

Where is your PRIMARY symptom located? _____

Approximately what date did this symptom begin? _____

How did your symptoms start (injury/gradual/sudden)? _____

Have you ever had this problem before? (circle one: Y N) If yes, please answer the next two questions:

What treatments helped? _____

What treatments failed? _____

What functions/activities could you perform before, that you now are unable to do? _____

What are your goals for therapy? _____

In the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

In the past month, have you often been bothered by little interest/pleasure in doing things? YES NO

Are these feelings, something with which you would like help? Yes, today Yes, but not today No

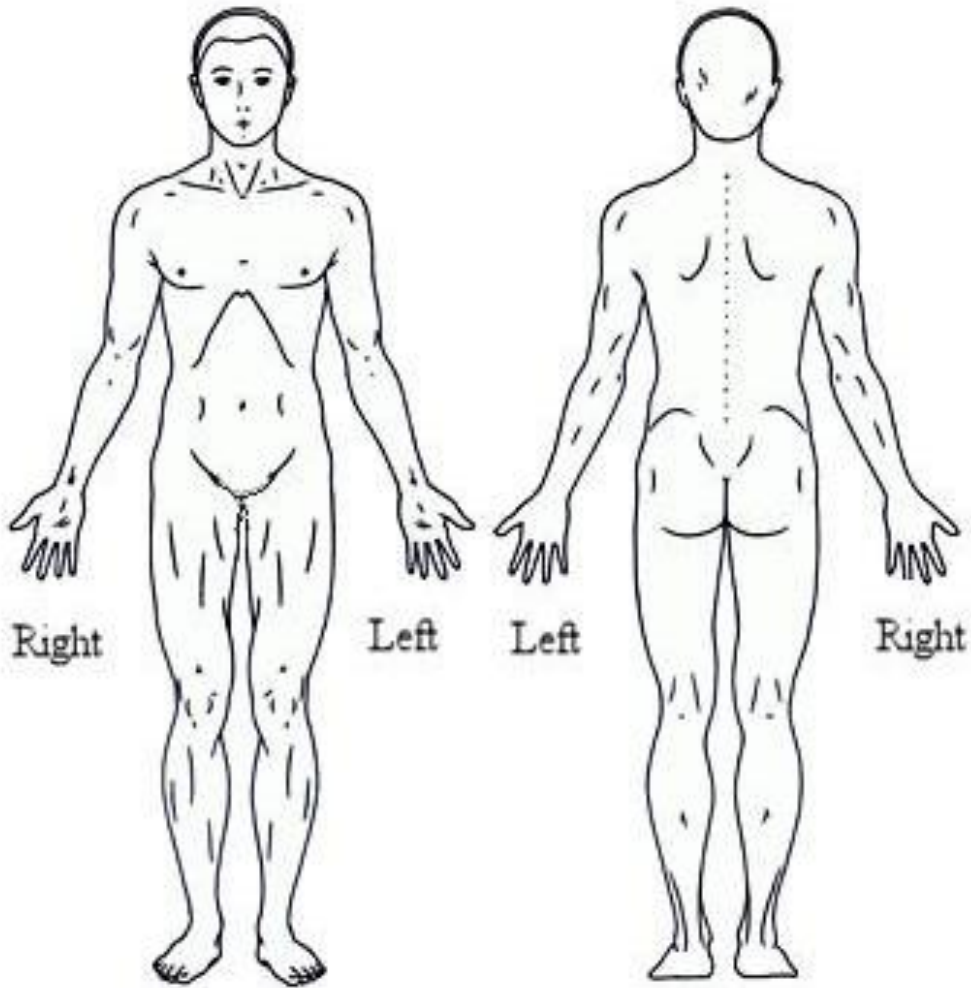
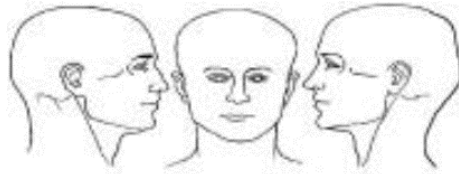
I certify that the above information is correct (patient/guardian signature): _____ **Date:** _____

Reviewed by (Therapist signature): _____ **Date:** _____

Patient Name: _____ DOB: _____

Symptom Types

- ↓ ↓ Shooting/sharp
- OO Dull/ache
- XX Numbness
- /// Tingling
- ^^^ Burning
- + + Tightness



- + / - N/T
- + / - Cough/Sneeze
- + / - Saddle Anesthesia
- + / - Bwl, Bldr Change

Primary Hyp:

Competing Hyp:

Complicating F's:

Problem 1: Name:		Cnst/Int	Cnsist/Var	Deep/Sup	B: /10	W: /10	C: /10
Agg	Time/Intensity	Ease	Time/Intensity	Resume Agg			
Problem 2: Name:		Cnst/Int	Cnsist/Var	Deep/Sup	B: /10	W: /10	C: /10
Agg	Time/Intensity	Ease	Time/Intensity	Resume Agg			