RIVER OAKS
PHYSICAL THERAPY
A Concierge Practice in Spine & Joint Manual Therapy

2900 Weslayan St, Suite 545
Houston, TX 77027
281-940-9423 Office
www.riveroakspt.com

New Patient Intake Form

Name:_____ ___ _____
First Middle Initial Last

Address: _____ _____ _____
Street City, State Zip

Telephone: _____ _____
Cell Home/Work

Date of Birth: _____

Email: _____

Emergency Contact _____

Emergency Contact Telephone Number _____

Relation _____

How did you hear about us?

_____

Do you have a pace maker or any surgical implants?

Yes No

If so, please explain

_____

RIVER OAKS
PHYSICAL THERAPY
A Concierge Practice in Spine & Joint Manual Therapy

2900 Weslayan St, Suite 545
Houston, TX 77027
281-940-9423 Office
www.riveroakspt.com

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Medicare Patients: We only provide covered services to beneficiaries in instances where the patient preemptively agrees that he/she wants to receive our services even though he/she will have to pay in full out-of-pocket, and he/she does not want to bill Medicare for the services.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____