

Dubrow Physical Therapy & Consultation Services
5856 Stone Meadow Drive
Plano, Texas 75093
972-398-0789

Patient Registration Form

(For our billing system to provide you an insurance accepted claim form.)

Today's Date: _____ Date of Birth: _____

Who referred you to Dr. Dubrow and/or how did you find us? _____

Name: _____ Jr. Sr.

First Middle Last

Address: _____

Street No. Street Name Apartment No.

City State Zip Code

Home Phone: _____ Cell Phone: _____

E-mail: _____

Marital Status: Single Married Divorced Widowed

Employer: _____

Name Address

Occupation: _____ Work Phone: _____

Emergency Contact: _____

Relationship: _____ Phone No.: _____

If patient is a child, parent's name(s): _____

Allergies: _____

Insurance Information:

Insurance Company: _____

Member ID No: _____ Name of Cardholder: _____

Cardholder's Date of Birth: _____

Patient's Relationship to Cardholder: _____

If an injury, was it due to an auto accident? Yes No Employment? Yes No

State in which accident occurred: _____ Date of accident: _____

Other injury? Yes No If yes, please explain: _____

Date of injury (if other than accident): _____

Referring Physician: _____ Phone No.: _____

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Financial Policies

We are dedicated to providing the best possible physical therapy services to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about our financial policies, please do not hesitate to discuss them with us.

Evaluation Fee:

Dr. Dubrow provides a full 90-minute history and physical evaluation. As of April 2026, there are only 1774 active Fellows of the American Academy of Orthopedic Manual Physical Therapists in the United States. These Fellows are Residency and Fellowship trained. Far less practicing Fellows have the opportunity to provide this comprehensive evaluation service due to the entities which employ them. Because Orthopedic Manual Physical Therapy is such a small segment of specialized physical therapists, insurance companies in the United States have not differentiated this specialty from basic physical therapy services. Dr. Dubrow treats a patient after a comprehensive evaluation as any competent and *specialized* medical professional. She uses her expertise to identify your specific issue(s) and then moves forward with treatment. Some insurance policies will not cover all of the evaluation and re-evaluation fee(s).

Guaranty of Payment: Payment is due at the time of service. We will provide you with a claim form for you to submit to your insurance company for potential reimbursement.

Method of Payment: We accept Zelle, cash, and credit/debit cards. The bank automatically charges a service fee for use of credit/debit cards.

Credit card information will be maintained on file as a guaranty of payment.

Should your credit card payment be declined for any reason and you fail to make satisfactory arrangements for payment, a claim may be filed against you in small claims court, or your account may be referred for outside collection.

Please provide your credit card information below. No one has access to our files. Your information is locked in a secure location, and your information is secure. **You will not be treated without providing your credit card information below.**

Number: _____ Expiration Date: _____
CVV Code: _____

I have read and understand the financial policies of Dubrow Physical Therapy and I agree to be bound by their terms.

Printed Name of Patient

Date

Signature of Patient or Responsible Party

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Cancellation and Late Policy

Dubrow Physical Therapy has been able to continue to offer incomparable Orthopedic Manual Physical Therapy for over 39 years. We are a boutique business and continue to provide you with unsurpassed care. Many other physical therapy clinics have four to five patients scheduled each hour per physical therapist. Dr. Dubrow sees one patient at a time.

Dr. Dubrow maintains a limited schedule to provide you with her attention. When ample time is not provided for a cancellation, Dr. Dubrow is unemployed for that open appointment time slot. She continues to have financial responsibilities of maintaining the office, staff, clinical, professional, city, state, and federal requirements, and quality of care. Additionally, because of her limited schedule, we have a patient waiting list. Those patients have a better opportunity to be seen when our cancellation policy is enforced.

The cancellation policy is strict and will not be waived. (Extreme exceptions will be reviewed.)

As of January 1, 2023, if you need to cancel your appointment, *this office requires 24-hour BUSINESS-DAY advance notice of your appointment cancellation; otherwise, a late/non-cancellation fee of \$175 is to be paid before your next visit.* (If your appointment is on Monday, we must have notification of cancellation by Friday at 1:00 p.m.)

TO CANCEL YOUR APPOINTMENT, CALL US AT 972-398-0789 (PLEASE LEAVE A MESSAGE IF WE DON'T ANSWER) OR TEXT US AT 469-782-4360.

The mission of Dubrow Physical Therapy is to provide exceptional care to accommodate the patient's needs. In order to do that, Dr. Dubrow needs the time she has reserved for you.

If you are filing our provided claim form with your insurance company and are more than eight (8) minutes late, those eight minutes cannot be filed with insurance. Therefore, for every eight minutes you are not at the clinic, you will be charged \$40 that we cannot charge to the insurance company.

When patients arrive 20 minutes late for their appointment, Dr. Dubrow is unable to accomplish the goals both you and she have for you for that appointment and for your overall goals.

Therefore, if you are 20 or more minutes late for a scheduled appointment, it will be considered a missed appointment, and you will be charged a non-cancellation fee of \$175.

I give my authorization to charge my credit card the fee(s) referenced above in case I do not follow the Cancellation and Late Policy. I have read and understand this policy.

Printed Name of Patient

Date

Signature of Patient or Responsible Party

Dubrow Office Signature

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by this office and how you can get access to this information. Please review it carefully. After reviewing this notice, you will be asked to sign that you have received this notice.

Dubrow Physical Therapy is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. This Notice describes how we will use and disclose your health information in our office. The policies outlined in this Notice apply to all of your health information generated by us in our office, whether recorded in your medical record, invoices, payment forms, or other ways. If you have questions about any part of this Notice or if you want more information about the privacy practices at Dubrow Physical Therapy please contact:

Designated Privacy Official
5856 Stone Meadow Drive
Plano, Texas 75093
972.398.0789

Effective Date of This Notice: May 1, 2014

- A. Your Rights. When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.
1. **Get a Copy of Your Medical Record.** You can ask to see or get a copy of your medical record and other health information this office has about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within thirty (30) days of your request. We may charge a reasonable, cost-based fee.
 2. **Ask us to Correct Your Medical Record.** You can ask our office to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within sixty (60) days.
 3. **Request Confidential Communications.** You can ask us to contact you in a specific way (for example, by home or office phone) or to send mail to a different address, or send email. We will say “yes” to all reasonable requests.
 4. **Ask us to Limit what we Use or Share.** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
 5. **Get a List of Those with Whom We’ve Shared Information.** You can ask for a list (accounting) of the times we’ve shared your health information for one (1) year prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

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6. Get a Copy of this Privacy Notice. You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
7. Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
8. File a Complaint if You Feel Your Rights are Violated. You can complain if you feel we have violated your rights by contacting our Designated Privacy Official (see above). You can also file a complaint with the Office for Civil Rights or you may visit:
www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

B. Your Choices. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

1. In These Cases, You have Both the Right and Choice to Tell us To: Share information with your family, close friends, or others involved in your care; and share information in a disaster relief situation. If you are not able to tell us your preference, *for example*, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
2. In These Cases we NEVER Share Your Information Unless you Give us Written Permission: Marketing purposes and the sale of your information.

C. Our Uses and Disclosures.

We typically use or share your health information in the following ways:

1. Treatment: We can use your health information and share it with other professionals who are treating you. *For example*, a doctor treating you for an injury asks another doctor about your overall health condition.
2. Running Our Office: We can use and share your health information to run our office, improve your care, and contact you when necessary. *For example*, we use health information about you to manage your treatment and services.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

3. Help with Public Health and Safety Issues: We can share health information about you for certain situations, such as: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and preventing or reducing a serious threat to anyone's health or safety.
4. Do Research: We can use or share your information for health research.
5. Comply with the Law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
6. Respond to Organ and Tissue Donation Requests: We can share health information about you with organ procurement organizations.
7. Work with a Medical Examiner or Funeral Director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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8. Address Workers' Compensation, Law Enforcement, and Other Government Requests: We can use or share health information about you for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.
9. Respond to Lawsuits and Legal Actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena. We make a concerted effort to contact you before we respond to a subpoena.

d. Our Responsibilities.

1. We are required by law to maintain the privacy and security of your protected health information.
2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. We must follow the duties and privacy practices described in this Notice and give you a copy of it.
4. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

E. Changes to this Notice. We may change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

F. This Notice applies to: **Dubrow Physical Therapy**
5856 Stone Meadow Drive
Plano, Texas 75093
office@dubrowpt.com
972.398.0789

G. The Effective Date of Notice is May 1, 2014.

Patient Acknowledgement: By signing my name below, I acknowledge receipt of a copy of this Notice, and my agreement to its terms.

Printed Name of Patient

Date

Signature of Patient or Responsible Party

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DISCLOSURE RECORD OF PATIENT INFORMATION

The Health Information Portability and Accountability Act (“HIPAA”) privacy rule gives a patient the right to deny certain uses and disclosures of their personal health information (“PHI”). The patient is also provided the right to request confidential communication and the manner in which the information is received.

Please note that restrictions in our ability to contact you may result in missed calls and miscommunication. We encourage you to make any restrictions that are necessary, but remember that communication is essential to effective healthcare.

I can be contacted in the following manner:

<input type="checkbox"/> Home Telephone _____ <i>Please check one</i> <input type="checkbox"/> <i>O.K. to leave message with detailed information</i> <input type="checkbox"/> <i>Leave message stating Dr. Dubrow’s name and call back number only</i>	<input type="checkbox"/> Written Communication <i>Please check all that apply</i> <input type="checkbox"/> <i>O.K. to mail to my home address</i> <input type="checkbox"/> <i>O.K. to fax to this number:</i> <input type="checkbox"/> <i>O.K. to email:</i> _____
<input type="checkbox"/> Work Telephone _____ <i>Please check one</i> <input type="checkbox"/> <i>O.K. to leave message with detailed information</i> <input type="checkbox"/> <i>Leave message stating Dr. Dubrow’s name and call back number only</i>	<input type="checkbox"/> Verbal Communication <i>Please check and fill out all that apply</i> <input type="checkbox"/> <i>O.K. to speak to spouse/significant other</i> <i>Name:</i> _____ <input type="checkbox"/> <i>O.K. to speak to child(ren)</i> <i>Name(s):</i> _____ _____ <input type="checkbox"/> <i>O.K. to speak to parent(s)</i> <i>Name(s):</i> _____ _____ <input type="checkbox"/> <i>O.K. to speak to my (note relationship(s))</i> <i>Name(s):</i> _____ _____
<input type="checkbox"/> Cell Phone _____ <i>Please check one</i> <input type="checkbox"/> <i>O.K. to leave message with detailed information</i> <input type="checkbox"/> <i>Leave message stating Dr. Dubrow’s name and call back number only</i> <input type="checkbox"/> <i>O.K. to text</i>	

FOR OFFICE USE ONLY

<i>Date</i>	<i>Disclosed to Whom (Phone or Fax # or Address)</i>	<i>Purpose of Disclosure</i>	<i>Disclosed by (Initials)</i>

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2026 Consultations

In-Person Consultation Appointments:

As an orthopedic manual physical therapist, Dr. Dubrow provides hands-on physical therapy in addition to a comprehensive program of Scientific Therapeutic Exercise Progressions to successfully treat her patients. Appointments are scheduled for 45 minutes, all of which is dedicated to offering you exceptional care for those services. If you wish for a detailed consultation regarding anatomy, physiology, biochemistry, physics, etc., underlying the primary reasons you may have a certain problem or the how and why she performs treatment interventions, you are offered a supplemental session, the fee of which is \$200 for 45 minutes.

If you are filing a claim form with your insurance company, the insurance company will not compensate an informational consultation (as mentioned above) for information only. Insurance will only reimburse you for advice managing your problem.

Phone, text, and email consultation fees:

Fees for consultations via phone, text, and email are as follows:

- Under 5 min: no charge
- 5-10 min: \$40
- 11-20 min: \$80
- 21-30 min: \$120

PHONE, TEXT, AND EMAIL FEES MUST BE PAID VIA ZELLE IMMEDIATELY AFTER THE CONSULTATION.

NOTE: In order for Dr. Dubrow to provide a consultation via text or email, you must sign a separate HIPAA release agreement.

I acknowledge that I understand and agree to the terms above.

Printed name of patient

Date

Patient Signature

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PHYSICIAN LIST

Name: _____

DOB: _____

Physician Name/Specialty: _____

Practice Name: _____

Address: _____

Phone Number: _____

Physician Name/Specialty: _____

Practice Name: _____

Address: _____

Phone Number: _____

Physician Name/Specialty: _____

Practice Name: _____

Address: _____

Phone Number: _____

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Patient Nutrition Form

NAME: _____

Please provide the specific number of servings PER DAY or per week, as indicated:

Caffeine: Yes No

How many **ounces** and **what type** of caffeine **PER DAY**? (medium coffee mug =10 oz)

Alcohol: Yes No

How many **servings** and **what type** of alcohol **per week**? (1 serving = 1 beer; 5 oz of wine; 1 oz of liquor)

Fried Foods: Yes No

How many **servings** and **what type** of fried food **per week**? (1 serving = ½ cup french fries; hamburger; fast food; fried chicken. The palm of your hand = 1 serving)

Gluten (wheat products): Yes No

How many **servings** of gluten **per week**? (1 serving = 1 slice of bread; ½ cup of pasta; ½ bagel; palm of crackers; 2-3 small cookies)

Sugar: Yes No

How many **servings** of sugar **PER DAY**? (1 tsp of sugar is a serving; 1 packet of sugar; one can of soda contains 9 1/3 tsp sugar)

Soda Yes No

How many **cans** of soda **per week**? (1 can of soda is 12 oz)

Grain-Fed Red Meat: Yes No

How many **servings** of **grain-fed beef** **per week**? If you don't specifically buy "grass fed" from a known organic source, you are buying grain-fed red meat. Beef served at a restaurant is generally grain-fed. (1 serving = palm of your hand)

Dairy Fat: Yes No

How many **servings** of dairy fat **PER DAY**? (1 serving = 1 Tbsp butter; ½ cup 2% or whole milk; 4 oz of cheese)

Shellfish: Yes No

How many **servings** of shellfish **per week**? (1 serving = 4 oz shrimp; lobster; crab; clams; mussels)

Fast Food: Yes No

How many **times** do you eat fast food **per week**?

Water: Yes No

How many **ounces** do you drink **PER DAY**? (A large cup from a fast food restaurant is usually 32 oz. A regular water glass is usually 8 oz. Purchased water bottles come in 8, 16 and 20 oz. _____)

Smoking: Yes No How many cigarettes **PER DAY**? _____ How many cigars **per week**? _____

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Patient History

Check any boxes that are applicable to you within the last **three months** (excluding vaccinations):

- | | |
|---|---|
| <input type="checkbox"/> General malaise (discomfort, feeling ill or poorly) | <input type="checkbox"/> Urinary changes |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Recent UTI |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Weight loss | |
| <input type="checkbox"/> Difficulty falling asleep or staying asleep | <input type="checkbox"/> Recent rash (Cause: _____) |
| <input type="checkbox"/> Appetite increase | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Appetite decrease | |
| <input type="checkbox"/> Deep, adherent scar tissue Location: _____ | |
| <input type="checkbox"/> Change of vision or loss of eyesight | |
| <input type="checkbox"/> Stuffiness in ears or sinuses | |
| <input type="checkbox"/> Numbness, tingling, or weakness in extremities | |
| <input type="checkbox"/> Right leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Right arm <input type="checkbox"/> Left arm | |
| <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Cough, shortness of breath, or asthma | |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Heart defects, issues, complications | |

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Screening Information and Questionnaire

Dr. Dubrow is a solo practitioner who provides you with the most advanced orthopedic manual physical care available on the market. In addition to exceptional education, experience, and applied knowledge, the practice of OMPT requires physical strength of the OMPT specialist. Because of this, Dr. Dubrow is extraordinarily careful to remain healthy. If she becomes sick, not only does she lose the ability to treat you for at least a week, her strength may be negatively affected for a month or more. Therefore, our clinic is careful to keep you healthy from the spread of infectious diseases and is careful to keep the one practitioner healthy and physically capable of providing you with outstanding care. At each visit our staff will ask you a few questions to determine whether a mask is necessary at your visit. If you've purchased a mask from us, please wear it only at our clinic and keep it with you in case you will be asked to wear it.

Check that which applies:

- I have felt unwell in the last 3 days.

- I am living in a household with someone who is feeling unwell (sniffles, etc.)

- I have symptoms of...
 - Sinus drainage, teary eyes, tickle/itchy throat
 - Sneezing or coughing
 - Sore throat, random body aches
 - Gastrointestinal problems (vomiting, nausea, diarrhea, upset stomach)

Please check:

- For my health and that of Dr. Dubrow, I understand Dubrow Physical Therapy may ask me to purchase and wear an FDA certified & tested for authenticity N95 mask for their cost of \$5 (cash or check only).