PHYSICAL THERAPY CENTER OF CHESAPEAKE

747 Volvo Parkway ◆ Suite 103 ◆ CHESAPEAKE, VA 23320 ◆ (757) 420-2880 FAX (757) 420-8090

WELCOME

Thank you for choosing us for your Physical Therapy needs.
In order to efficiently process your information the following should be filled out as accurately as possible. If you have any questions, please do not hesitate to ask the receptionist for assistance.

PERSONAL INFORMATION
NAME: _____ HOME PHONE _____
ADDRESS: _____ CELL PHONE _____
CITY/STATE/ZIP: _____ Email: _____

Referring Physician _____

BIRTH DATE: _____ SOCIAL SECURITY # _____
EMPLOYER: _____ PHONE: _____
ADDRESS: _____
CITY/STATE/ZIP: _____

SPOUSE/PARENT
NAME: _____ PHONE: _____

EMPLOYER: _____ PHONE: _____

ADDRESS/CITY/STATE: _____

EMERGENCY CONTACT (other than above)
NAME: _____ PHONE: _____ RELATION# _____

INSURANCE INFORMATION (MUST BE FILLED IN)
PRIMARY INSURANCE: _____ POLICY # _____
GROUP# _____ POLICYHOLDER _____ RELATION _____

SECONDARY INSURANCE: _____ POLICY# _____
GROUP: _____ POLICYHOLDER _____ RELATION _____

IF THIS WAS DUE TO AN INJURY THIS INFORMATION MUST BE FILLED IN
WAS THIS DUE TO AN INJURY? YES/NO WORK RELATED? YES/NO
AUTO ACCIDENT? YES/NO

DATE OF INJURY: _____ TIME OF INJURY: _____
DATE OF FIRST MEDICAL ATTENTION: _____ TIME _____

WORKERS COMPENSATION INFORMATION:
NAMEOFEMPLOYER _____ PHONE: _____
ADDRESS _____ CONNTACT PERSON _____

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Name:_____ Date of Birth:_____ Age:_____ Appt Date: _____

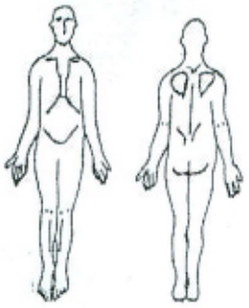
Please describe the onset of your injury and/or pain for which you are seeking treatment:

_____

_____

Circle area that applies

Date of Surgery: _____



Circle symptoms that apply

Aching pain throbbing tingling

Sharp pain dull pain stiffness

Burning numbness

Severity of pain (scale of 0 – 10)

Best – 0 1 2 3 4 5 6 7 8 9 10

Worst – 0 1 2 3 4 5 6 7 8 9 10

Medical information: please check all that apply

___heart disease ___high blood pressure ___cancer ___are you pregnant

___diabetes ___asthma ___fainting Are you latex sensitive? YES NO

___pacemaker ___RA/RO ___seizures ___other:_____

Have you had 2 or more falls or any falls with injury in the past year? YES NO

List of prescription medication or over the counter supplements:

Name dosage how often you take it why

_____

_____

_____

_____

_____

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Office Policy

I. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize Physical Therapy Center of Chesapeake to release any financial, medical or other such information that may be requested or required by any insurer of the party responsible for any or all charges incurred for my case. I authorize Physical Therapy Center of Chesapeake to contact my employer and/or insurance carrier to verify coverage.

II. **AGREEMENT OF BENEFITS:** I authorize payment of benefits to be paid directly to Physical Therapy Center of Chesapeake to be applied to all covered services on my balance. I agree to be responsible for all charges not covered or paid for under my present insurance policy. If my insurance carrier makes payment directly to me, I realize that the balance becomes my responsibility.

III. I understand that a $25.00 fee is charged for any checks returned for insufficient funds or other reasons

IV. I understand that Physical Therapy Center of Chesapeake will consider any bill past due 30 days from the date reflected on the invoice. It is understood that the usual and customary collection procedures may be initiated should the account become delinquent. Interest of 2% per month may be charged on unpaid balances over 30 days, and any collection costs up to 33% may be added to the amount due. The patient and/or responsible party will be held liable for any or all collection, lawyer, and court costs incurred in collection proceedings of past due amounts.

V. According to the Privacy Act, all charts/files will be held for 6 years and properly disposed of thereafter. Unless the patient is a minor at the time of treatment, the file will be kept until that patient has turned 18 years of age.

I permit a copy of this authorization to be used in place of the original, regardless of the date, until cancelled by me.

I certify that the information provided by me regarding my insurance coverage is correct and that the above release and request for assignment will be honored. By signing below, I attest that I understand and agree to the above provisions and conditions.

Patient_____ Responsible Party_____ Date_____

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Acknowledge of Notice of Privacy Practices

Physical Therapy Center of Chesapeake reserves the right to modify the privacy practices outlined in the notice.

_____ I have received a copy of the Notice of Privacy Practices for Physical Therapy Center of Chesapeake

_____ I have opted not to receive a copy of the Notice of Privacy Practices for Physical Therapy Center of Chesapeake but have been made aware of the policy posted in the office.

Release of Medical Information

This notice confirms that I, _____, authorize Physical Therapy Center of Chesapeake and staff to release any and all medical information to:

_____ Referring Physician

_____ Family Physician/Internist

and/or_____ Spouse/Guardian

_____ Other

until further notice.

You may revoke or terminate this authorization by submitting a written revocation to Physical Therapy Center of Chesapeake.

_____ Patient's Name

_____ Signature of Patient or Guardian

_____ Date

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Consent for Treatment Form

Consent for Treatment

I give my permission for treatment by the health care professional staff of Physical Therapy Center of Chesapeake to provide physical therapy and rehabilitation services and necessary treatment as prescribed by my physician. I understand that to evaluate and treat my condition, the therapy staff must have visual or physical access to the areas of my body which may be experiencing and/or causing pain. I also understand that the rehabilitation process involves certain inherent and unavoidable risks including falls, injuries to other body parts and other similar injuries and that the only alternative to entirely avoid these risks would be to forgo rehabilitation all together. I understand that it is my responsibility to immediately communicate any difficulties or concerns that I have regarding my current health status and my response to any treatment received. As with any course of treatment there is always the possibility of an unexpected complication and no guarantee or assurance has been made as to the results of treatment.

The following is a list of modalities and procedures potentially used in physical therapy. Your therapist will explain which ones will be used during your treatment; discuss treatment alternatives and goals of treatment with you.

Evaluation	Ultrasound	Taping
Heat	Joint Mobilization	Postural Training
Ice	Joint Manipulation	Therapeutic Exercise
Electrical Stimulation	Muscle Stretching	Functional Training
Muscle Release Techniques	Traction	Iontophoresis

During your physical therapy it is often necessary to expose or touch the area to be treated. Every effort is made to preserve modesty and keep you comfortable. Our office employs both male and female therapists. Please communicate with our office staff if the gender of your therapist is important to you.

Patient Signature:_____ Date:_____