VILLAGE PHYSICAL THERAPY
PATIENT INFORMATION

PLEASE PRINT

PATIENT NAME: ____

DATE OF BIRTH: ______________ **SEX: MALE FEMALE SOCIAL SECURITY #:** _______-_______-_______

STREET ADDRESS: ____

CITY: ______________________________ **STATE:** __________ **ZIP CODE:** __________

HOME #: ______________________ **WORK #:** ______________________ **CELL #:** ______________________

SPOUSE INFORMATION Not Applicable

NAME: ____

HOME #: ______________________ **WORK #:** ______________________ **CELL #:** ______________________

EMERGENCY CONTACT INFORMATION

Same as spouse? **YES NO**

NAME: ______________________________ **RELATIONSHIP:** ______________________

HOME #: ______________________ **WORK #:** ______________________ **CELL #:** ______________________

GUARANTOR AND RESPONSIBLE PARTY

SELF OTHER: ______________________________ **RELATIONSHIP:** ______________________

IF THE GUARANTOR HAS A DIFFERENT ADDRESS PLEASE FILL OUT BELOW:

NAME: ____

ADDRESS: ____

PHONE #: ______________________________

NO SHOW AND CANCELLATION POLICY

We understand there are times when you must miss an appointment due to emergencies or obligations to work and family. However, when you don't call to cancel an appointment we are unable to offer this slot to another patient for treatment. If you NO SHOW for an appointment, OR CANCEL without a 24 hour notice you will be charged a $30.00 fee.

YOU WILL BE RESPONSIBLE FOR THIS FEE

SIGNATURE: ____

DATE: ______________________________

VILLAGE PHYSICAL THERAPY
INSURANCE INFORMATION SHEET

PATIENT NAME: ____

PRIMARY INSURANCE: ____

POLICY HOLDER NAME: SELF OTHER: ______________________________________

RELATIONSHIP to PATIENT : ____________________________

POLICY HOLDER BIRTH DATE: _______________ SOCIAL SECURITY #:_______________________

SECONDARY INSURANCE: ____

POLICY HOLDER NAME: SELF OTHER: ______________________________________

RELATIONSHIP to PATIENT: ______________________

POLICY HOLDER BIRTH DATE: _______________ SOCIAL SECURITY #:_______________________

AUTO ACCIDENT? YES NO

WORKMAN'S COMPENSATION? YES NO If yes fill information below:

NAME OF EMPLOYER: ____

PHONE NUMBER: ___________________________SUPERVISOR NAME: _________________________

WORK ADDRESS: ____

CASE MANAGER NAME: ____________________________________PHONE: ______________________

ATTORNEY INVOLVED? YES NO If yes fill information below:

NAME OF ATTORNEY: ____

ADDRESS: ____

PHONE NUMBER: ____________________________

AUTHORIZATION TO PAY:

I hereby authorize payment directly to Village Physical Therapy. I realize that I am responsible for non-covered services. I also understand that I am responsible for any other costs incurred while collecting my outstanding balances.

Signature: ____ Date: _______________

WAIVER:

I am electing to be treated today and agree to pay for services if not covered by my insurance if I did not bring a referral as required by my Insurance Company, or I do not have my insurance card.

Signature: ____ Date: _______________

VILLAGE PHYSICAL THERAPY
1936-B Opitz Boulevard
Woodbridge, VA 22191

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_________ I understand that, under the *Health Insurance Portability & Accountability Act of 1996 ("HIPPA")*,
(Initials) 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 acknowledge that I have been offered a copy of your *Notice of Privacy Practices* containing a more complete
(Initials) description of the uses and disclosures of my health information. 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 above 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 or disclosed
(Initials) to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request, but if you do agree then you are bound to abide by such restrictions.

_________ I give permission for Village Physical Therapy staff to leave any necessary medical information regarding
(Initials) my care on my answering machine, if I am not available.

Print Name: ____ **Date:** ______________________________

Signature of Patient: ____

Parent / Legal Guardian: _____________________________________
(if patient is under 18)

VILLAGE PHYSICAL THERAPY
PATIENT MEDICAL HISTORY

Patient Name: ____**Date:** ____________________________

Age: _________ **When did injury occur/ symptoms begin?** _____________________________

How did injury occur?/ How did symptoms begin?

____

____

____

1. Which applies to your condition?
Motor Vehicle Accident Work Related Injury Athletic/Recreational Injury
Lifting Injury Cause Unknown Other: ____________________

2. Are you currently working? Yes No Occupation: ______________________

3. Please list your primary leisure activities:

4. Are you pregnant? Yes No

5. Last seen by referring Physician (date) ______________ **Next Appointment** (date) ______________

6. Have you had any of the following diagnostic tests for this issue? (Check all that apply)
X-Ray MRI CT/CAT EMG/Nerve
Other ______________________________

Results: ____

7. Have you received previous treatment for this issue? YES NO
If yes, please explain (ie- surgery, hospitalization, PT, injections, etc):

____

____

____

8. Are you currently being treated by any other physician or therapist?
If yes, please list their name & your condition being treated.

1. _________________________ Condition: ____
2. _________________________ Condition: ____
3. _________________________ Condition: ____
4. _________________________ Condition: ____

9. Have you recently noted: (Check all that apply)

Unexplained Weight Loss / Gain --- how much? __________
Nausea / Vomiting
Fatigue
Weakness / Lethargy
Fever /Chills / Night Sweats
Numbness / Tingling
Loss of Appetite
Other_________________________

10. Do you have/ have you had any of the following problems? (Check all that apply)

YES	NO	SYMPTOMS	YES	NO	SYMPTOMS
		Alcoholism			**Heart Disease Problems**
		Angina			**Heart Attack**
		Asthma			**Heart Palpitations**
		Back Injury			**Kidney Problems**
		Breathing Difficulties			**Nausea**
		Bronchitis			**Metal Implants**
		Blood Disorder			**Multiple Sclerosis**
		Bleeding			**Other Condition of Nervous System**
		Cancer			**Osteoarthritis**
		Chemical Dependency			**Osteoporosis**
		Chest Pain			**Pacemaker**
		Diabetes			**Respiratory Problems**
		Dizziness			**Rheumatoid Arthritis**
		Depression			**Seizures**
		Epilepsy			**Skin Abnormalities**
		Emphysema			**Stroke**
		Fracture			**Smoking**
		Fainting			**Surgeries** (list below)
		Headaches			**Vomiting**
		High Blood Pressure			**Other** (list below)

If yes to any of the above, please explain/ list:

____

____

11. Do you have any allergies, including food related? YES NO

If yes, please list:

____

____

12. Please list current medications & conditions for which they are taken:

(include prescriptions, over the counter medicines, vitamins, herbal supplements).

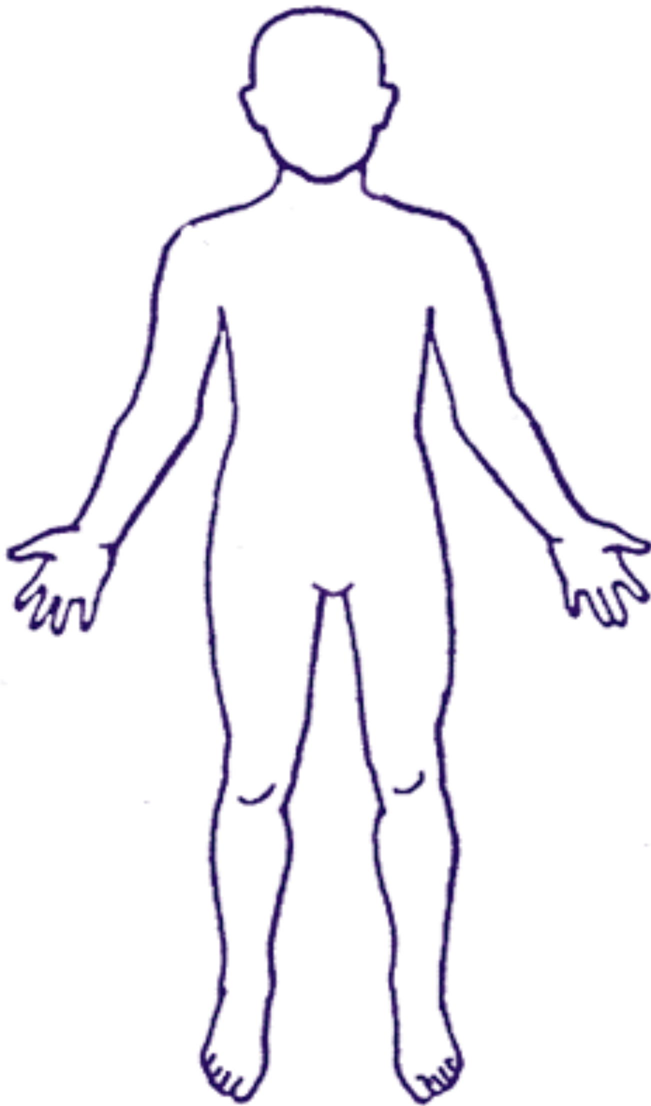
____

____

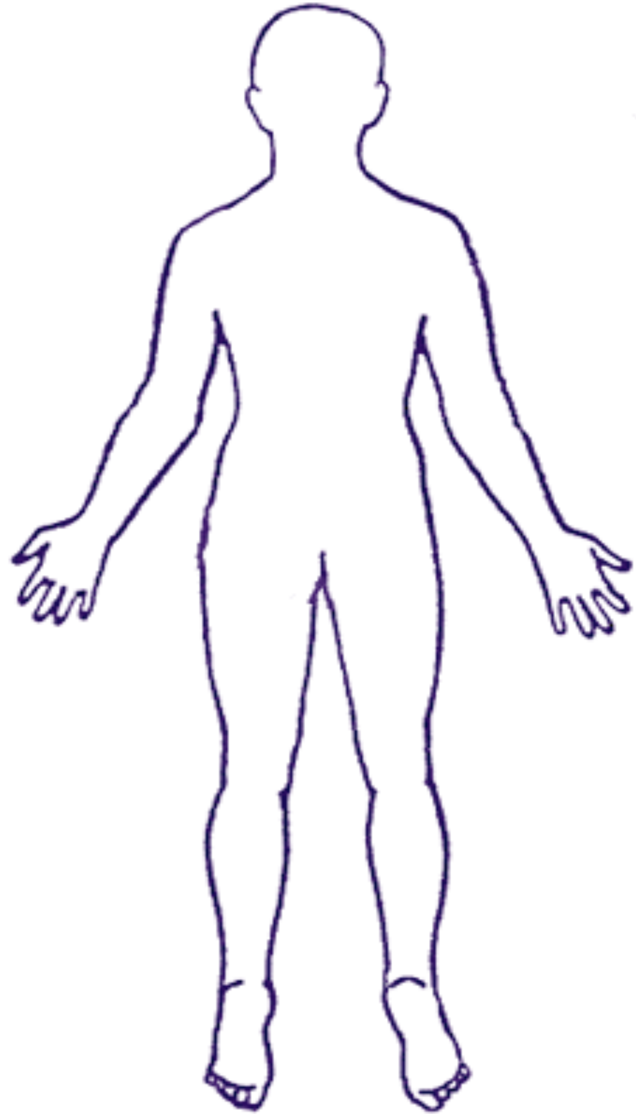
____

13. Please use the diagram below to indicate where you feel symptoms right now.
Use the following key to indicate your different symptoms:

□ **Pins & Needles** = ++++ □ **Stabbing** = / / / /
□ **Burning = XXXX** □ **Deep Ache = 0000**



(front)



(back)

The above stated information is true and accurate to the best of my knowledge.

Print Name: ____ **Date:** _____________

Patient's Signature: ____

Signature of Parent or Legal Guardian: ____
(if patient is under 18)