

**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.

**AUTHORIZATION TO PAY**

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

**WAIVER (if applicable)**

\_\_\_\_\_ 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  
(Initials) as required by my insurance company, or I do not have my insurance card.

**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.  
(Initials) 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.**

**Print Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**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?**

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**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):

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**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)

- 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:**

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**11. Do you have any allergies, including food related?**

YES

NO

If yes, please list:

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

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

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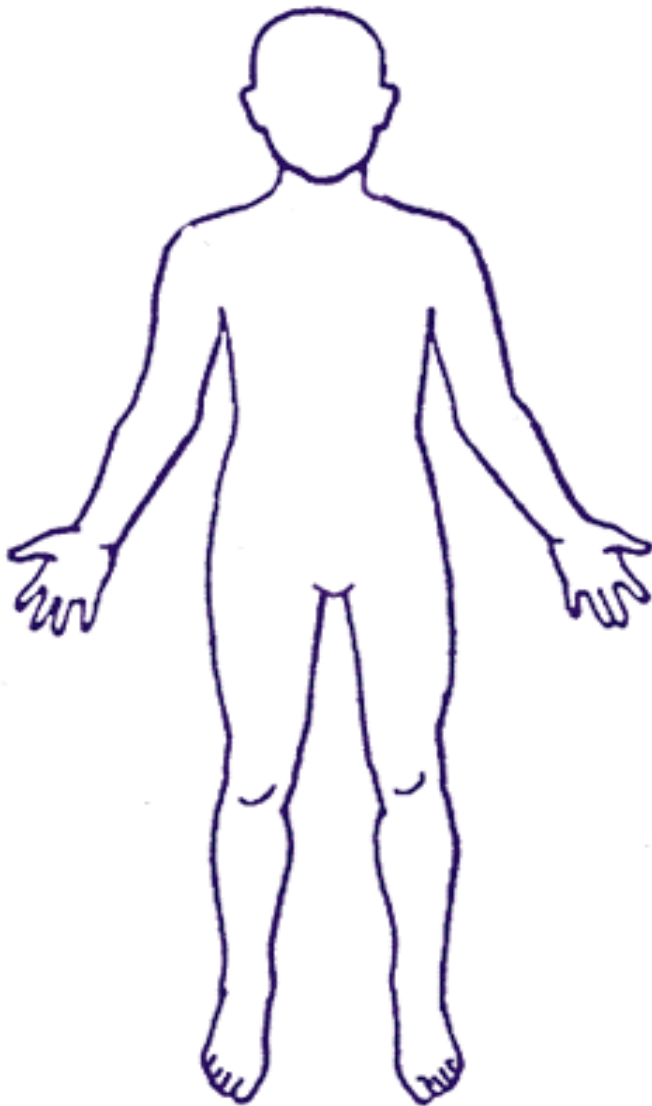


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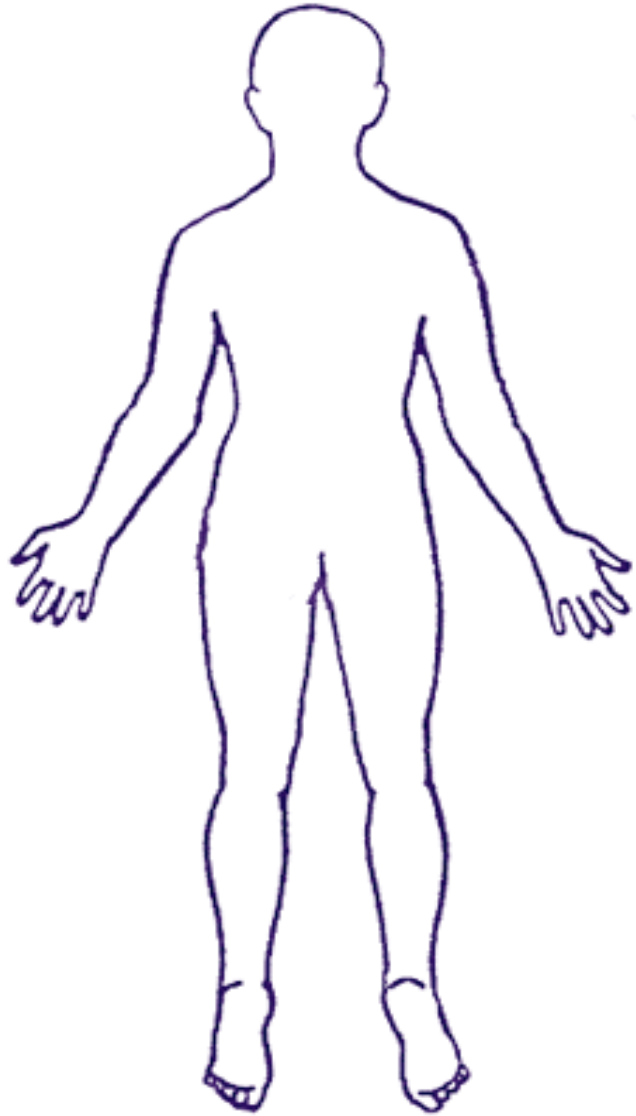
**13. Please use the diagram below to indicate where you feel symptoms right now.**

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)