PATIENT INFORMATION

Today's Date:_____

Name:_____SS#:_____-_____-_____
First MI Last **(REQUIRED FOR WORK COMP & VA ONLY)**

☐ Male ☐ Female Date of Birth____/____/____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____
Street Address City State Zip

Email Address:_____Fax: (_____) _____-_____

Would you like to receive appointment reminders by email? ☐ Yes, notify me by email ☐ No, Do not email me

Home Phone: (_____) _____-_____ ☐ Work or ☐ Cell Phone: (_____) _____-_____

Would you like to receive appointment reminders by text? ☐ Yes, notify me by text ☐ No, Do not text me

Driver's License #:_____State Issued:_____ **Please provide a copy for our records**

Employer:_____ Occupation:_____
(REQUIRED FOR WORKER COMPENSATION CASES)

Emergency Contact:_____ Phone: (_____) _____-_____Relation:_____

Have you had Physical or Occupational Therapy this year for any condition? ☐ Yes ☐ No

PHYSICIAN INFORMATION

Referring Physician:_____Date of Injury:_____

Office Address:_____Phone: (_____) _____-_____
Street Address City State Zip

APPOINTMENT POLICY

I understand that my doctor has prescribed physical therapy for me and physical therapy is an on-going process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three (3) consecutive appointments, MVP Physical Therapy has the right to discharge me from care for being non-complaint with my physician's orders.

I understand and agree that **MVP Physical Therapy** requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $25 charge (which is not covered by insurance)

Signature:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

CONSENT FOR TREATMENT

I the Undersigned do hereby agree and give my consent for **MVP Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition. I also authorize MVP Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Signature:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. If I do not provide insurance information or inaccurate information, MVP Physical Therapy will bill me directly for incurred charges, as well as for charges not covered by my insurance plan. If I receive a notice from my insurance company that payment is delayed or denied because additional information is required, I will contact my insurance company so that claims may be reprocessed and paid.

I hereby give authorization for payment of insurance benefits made directly to MVP for services rendered. In the event that my insurance company forwards payment directly to me, instead of MVP, I will immediately deliver said payment to MVP.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand and agree that if it becomes necessary to commence legal actions for the collection of outstanding charges on my account, I will be responsible for any costs and/or court fees, in addition to the outstanding balance.

Signature of Person Responsible for Charges:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

PRIMARY INSURANCE

Name of Subscriber:_____ _____Date of Birth____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Address of Subscriber:_____
(If Different Than Patient) Street Address City State Zip

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ SS#:_____-____-_____
(If Different Than Patient)

Insurance Co:_____ Phone: (_____) _____-_____

Subscriber #:_____Group#/Name:_____

Subscriber's Employer:_____ Phone: (_____) _____-_____

SECONDARY INSURANCE

Name of Subscriber:_____ _____Date of Birth____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Address of Subscriber:_____
(If Different Than Patient) Street Address City State Zip

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ SS#:_____-____-_____
(If Different Than Patient)

Insurance Co:_____ Phone: (_____) _____-_____

Subscriber #:_____Group#/Name:_____

Subscriber's Employer:_____ Phone: (_____) _____-_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF RELEASE OF SPECIFIC INFORMATION

Patient Name:_____ Clinic:_____

MVP Physical Therapy reserves the right to modify the privacy practices outlined in this notice.

I acknowledge that I have received or have had the opportunity to receive a copy of the official Notice of Privacy Practices from MVP Physical Therapy, Inc.

Signature:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

Initial all statements that apply:

_____ I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

_____ I authorize you to discuss my appointments with my spouse as listed on my patient information.

_____ In addition to my referring doctor, I authorize you to communicate with and send reports & evaluations to the following:

_____

_____

By signing this authorization, I understand that this does not authorize release of medical information by MVP Physical Therapy, Inc. to any other organization or agency unless I grant further authorization. I also understand that these authorizations may be revoked at anytime.

Signature:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

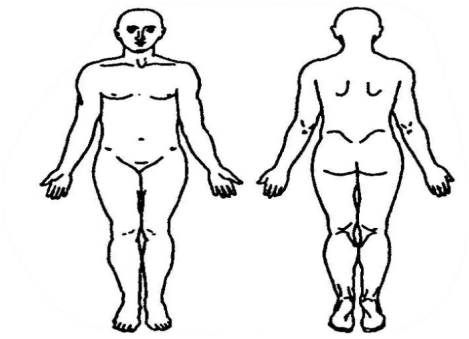
HEALTH HISTORY

Patient Name:_____ Height____Weight_____ Date of Birth___/___/__

CURRENT COMPLAINTS

How and when did your injury/condition/surgery begin?_____
What makes your pain increase?_____
What makes your pain decrease?_____
How long does it take for your pain to subside?_____
Have you ever had a similar injury/condition in the past?_____
Is your injury/condition **getting better**, **staying the same**, or **getting worse**? (Circle one)

Please mark **X**'s on the figure where your current symptoms are located



Please circle your current symptoms below

Sharp	Aching	Numbness
Tingling	Pulling	Burning
Dull	Heavy	Tight
Shooting	Throbbing	Stabbing

Other:_____

Rate your pain level over the last week at its best and at its worst on the scale below

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**

On the percentage scale below, circle your current level of overall function

NO RESTRICTIONS 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% **UNABLE TO FUNCTION**

Are you currently working? YES NO

Do you have any work restrictions? YES NO

Please specify any work restrictions given to you by your doctor

_____
_____

Please list any specific limitations you have due to your current symptoms

At Home: _____

At Work: _____

At Leisure: _____

MEDICAL HISTORY

Allergies	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Dizzy Spells	☐ Yes	☐ No	Parkinsons	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Emphysema/Bronchitis	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Gallbladder Problems	☐ Yes	☐ No	Speech Problems	☐ Yes	☐ No
Cardiac Conditions	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Strokes	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulation Problems	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Currently Pregnant	☐ Yes	☐ No	Metal Implants	☐ Yes	☐ No			

Describe any other conditions or precautions:

FALL HISTORY

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of Fall:_____

Two or more falls in the last year? ☐ Yes ☐ No Dates of Falls:_____

SURGICAL HISTORY

Body Region:_____	Surgery Type:_____	Date of Surgery:_____
Body Region:_____	Surgery Type:_____	Date of Surgery:_____
Body Region:_____	Surgery Type:_____	Date of Surgery:_____
Body Region:_____	Surgery Type:_____	Date of Surgery:_____
Body Region:_____	Surgery Type:_____	Date of Surgery:_____

CURRENT MEDICATIONS

Drug:_____	Dosage:_____	Reason for Taking:_____
Drug:_____	Dosage:_____	Reason for Taking:_____
Drug:_____	Dosage:_____	Reason for Taking:_____
Drug:_____	Dosage:_____	Reason for Taking:_____
Drug:_____	Dosage:_____	Reason for Taking:_____
Drug:_____	Dosage:_____	Reason for Taking:_____
Drug:_____	Dosage:_____	Reason for Taking:_____
Drug:_____	Dosage:_____	Reason for Taking:_____

PERSONAL INJURY FORM

Patient Name: _____ Street Address: _____
City/State/Zip: _____
Date of Accident/Injury: _____ Time: _____ am / pm (please circle one)
Cause: _____
Place (be specific): _____
Injury to (such as back, knee, neck): _____
I was: ( ) Driving my car ( ) Passenger in my car ( ) Pedestrian
( ) Driving another's car ( ) Passenger in another's car ( ) Other _____

Please list information regarding your automobile insurance company (or the insurance company of the owner of the vehicle in which you were a passenger or driver) **and** the insurance company of the third party (other vehicle involved, if any). If this injury is related to other than an automobile accident, please list the insurance company of the other party involved in this injury.

Your Auto (PIP) Insurance Company: _____
Mailing Address: _____
_____
Insured's Name: _____ Claim Number: _____
Insurance Claims Adjuster: _____ Telephone #: _____
I do <u>NOT</u> wish insurance billing or medical records to be issued to this party. _____
Initials
Reason: _____

Third Party Insurance Company: _____
Mailing Address: _____
_____
Insured's Name: _____ Claim Number: _____
Insurance Claims Adjuster: _____ Telephone #: _____
I do <u>NOT</u> wish insurance billing or medical records to be issued to this party. _____
Initials
Reason: _____

Please check the appropriate boxes below:
I have automobile insurance PIP (medical) coverage: ( ) Yes ( ) No
My automobile insurance PIP is exhausted: ( ) Yes ( ) No
I have personal Medical Insurance: ( ) Yes ( ) No
I have retained an attorney: ( ) Yes ( ) No
If yes: Attorney's Name: _____ Telephone #: _____
Mailing Address: _____
I do <u>NOT</u> wish insurance billing or medical records to be issued to this party. _____
Initials

Reason: _____

CONTRACTUAL GUARANTEE OF PAYMENT FOR HEALTH CARE SERVICES

Patient Name:_____ Clinic Location:_____

I fully understand that I am directly and fully responsible to MVP Physical Therapy, Inc. for all medical bills submitted by the clinic for services rendered me. Further, this agreement is made solely for said clinic's additional protection and in consideration of the company awaiting payment. I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages. **I also understand that my responsibility to pay my medical bill is independent and separate from MVP Physical Therapy's right to file a lien to protect its financial interest under RCW 60.44.**

I hereby authorize and direct you, my attorney, to pay directly to MVP Physical Therapy, Inc. such sums as may be due and owing for health care services for injuries arising from a motor vehicle collision. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect said company. I hereby further consent to a lien being filed on my case by MVP Physical Therapy against all proceeds of my settlement, judgment, or verdict, which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated in connection therewith.

I agree to never rescind this document and that any attempted rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor the Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I specifically request my attorney to acknowledge this letter by signing below and returning it to the therapy office. I have been advised that if my attorney does not wish to cooperate in protecting the clinic's interest, the company will not await payment, but will require me to make payments on a current basis.

_____

Signature of Patient/Guardian Date

_____

Patient's Driver's License Number

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect MVP Physical Therapy, Inc.

_____

Signature of Attorney Date

Please sign, date and return to MVP Physical Therapy, Inc.

Thank you.

Please return to this address: