PATIENT INFORMATION

Today's Date:_____

Name:_____SS#:_____-_____-_____
First Middle 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:_____

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?_____

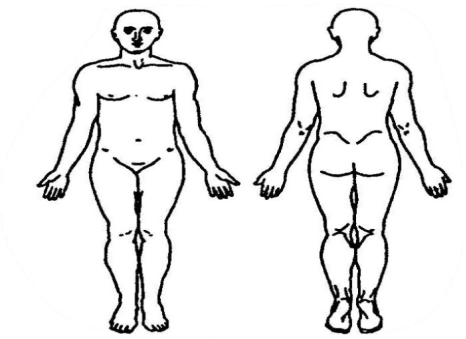
What makes your pain decrease?_____

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	Dizzy Spells	☐Yes ☐No	Metal Implants	☐Yes ☐No
Anemia	☐Yes ☐No	Emphysema/Bronchitis	☐Yes ☐No	MRSA	☐Yes ☐No
Anxiety	☐Yes ☐No	Fractures	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Arthritis	☐Yes ☐No	Fibromyalgia	☐Yes ☐No	Muscular Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Gallbladder Problems	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Auto Immune Disease	☐Yes ☐No	Headaches	☐Yes ☐No	Parkinsons	☐Yes ☐No
Cancer	☐Yes ☐No	Hearing Impairment	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Cardiac Conditions	☐Yes ☐No	Hepatitis	☐Yes ☐No	Seizures	☐Yes ☐No
Cardiac Pacemaker	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Smoking	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Speech Problems	☐Yes ☐No
Circulation Problems	☐Yes ☐No	HIV/AIDS	☐Yes ☐No	Strokes	☐Yes ☐No
Currently Pregnant	☐Yes ☐No	Incontinence	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Depression	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Diabetes	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Vision Problems	☐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:_____

CURRENT MEDICATIONS

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