



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 any time.

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? _____

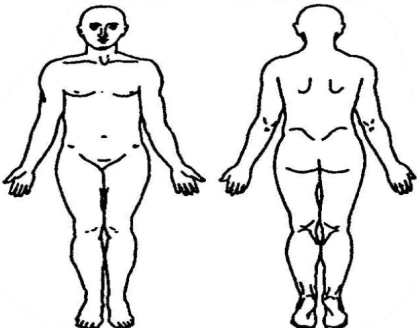
What makes your pain increase? _____

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)

<p>Please mark X's on the figure where your <u>current</u> symptoms are located</p> <div style="text-align: center;">  </div>	<p>Please circle your <u>current</u> symptoms below</p> <table style="width:100%; border: none;"> <tr> <td style="padding: 5px;">Sharp</td> <td style="padding: 5px;">Aching</td> <td style="padding: 5px;">Numbness</td> </tr> <tr> <td style="padding: 5px;">Tingling</td> <td style="padding: 5px;">Pulling</td> <td style="padding: 5px;">Burning</td> </tr> <tr> <td style="padding: 5px;">Dull</td> <td style="padding: 5px;">Heavy</td> <td style="padding: 5px;">Tight</td> </tr> <tr> <td style="padding: 5px;">Shooting</td> <td style="padding: 5px;">Throbbing</td> <td style="padding: 5px;">Stabbing</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Other: _____</td> </tr> </table>	Sharp	Aching	Numbness	Tingling	Pulling	Burning	Dull	Heavy	Tight	Shooting	Throbbing	Stabbing	Other: _____		
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**

<p>Are you currently working? YES NO</p> <p>Do you have any work restrictions? YES NO</p>	<p>Please specify any <u>work</u> restrictions given to you by your doctor</p> <p>_____</p> <p>_____</p>
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Please list any specific limitations you have due to your current symptoms

At Home: _____

At Work: _____

At Leisure: _____



MEDICAL HISTORY

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gallbladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No

Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parkinsons	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe any other conditions or precautions:

FALL HISTORY

Is your 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: _____



**2018 MEDICARE REQUIREMENTS FOR
OUT-PATIENT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY**

We are proud to be a Medicare Participating Provider and happy to provide all our Medicare patients the highest quality of care available.

Beginning January 1, 2018, out-patient Physical and Speech (combined) and Occupational Therapy each have a maximum allowable of \$2010.00 per year. This means that approximately 17 visits per calendar year will be covered by Medicare. This allowable may be extended if the injury or illness falls under the cap exception set-up by Medicare.

If you exceed your Medicare allowable, you may be asked to sign an Advanced Beneficiary Notice (ABN) form. This form will explain your options for continuing your treatment.

Please initial that you have read and understand the Medicare limitations for 2018. _____

HOME HEALTH QUESTIONNAIRE

Medicare will not provide coverage for out-patient therapy services if you are currently receiving home health care services for any reason. If you are receiving home health services **at this time**, you must be report it to us. If you have received home healthcare in the last 6 months, we respectfully request a copy of the discharge paperwork for our files.

Please initial the statement which describes your current situation regarding home healthcare.

_____ I am currently receiving home healthcare.

_____ I have not received any home healthcare in the last 6 months.

_____ I have been discharged from home health care in the past 6 months and will provide a copy of my discharge paperwork. I understand that Medicare must have this discharge date on file, in order for me to receive out-patient Physical or Occupational Therapy services from MVP Physical Therapy.

Patient Signature: _____ Date: _____



In order for us to comply with the Medicare as Secondary Payer laws, you must complete this form before we can properly process your insurance claim. Please complete this questionnaire and return it to the front desk. Do not hesitate to ask for clarification for any item on this form.

- 1. I am working full-time ___ part-time ___. I retired on ___/___/____.
2. A. I had a job-related injury on ___/___/____.
B. I had an organ transplant on ___/___/____.
C. I have been on kidney dialysis since ___/___/____.
D. I am being treated for an injury received in a car accident which occurred on ___/___/____.
Other vehicle (please identify): _____
E. Other type of accident (Date and Place where the accident occurred): ___/___/____

3. PLEASE CIRCLE YES OR NO.

- A. I am entitled to Black Lung Benefits. NO YES
B. I have a fee service card from the VA. NO YES
C. I am covered by Medicaid. NO YES If YES, ID #: _____

4. TO ALL STATEMENTS BELOW THAT APPLY TO YOU: CIRCLE YES OR NO

- A. I am enrolled in a Medicare HMO plan. NO YES
B. I/My Spouse has purchased a private insurance policy to supplement Medicare. NO YES
C. I have health insurance through my/my spouse's previous employer or union. NO YES
D. I am retired and covered by an employer-sponsored retiree health plan. NO YES
E. I am retired, but have been called back temporarily and have employee health benefits while I am working. NO YES
F. I/My spouse is employed and I am covered by an employer-sponsored health care program covering more than 20 employees NO YES

If you circled YES to any of the statements in question 4: Name of Plan: _____

Subscriber/ID #: _____ Name of Subscriber: _____

I certify that the answers above are true to the best of my knowledge. I will notify MVP Physical Therapy to any changes to my coverage during my treatment.

(Patient or Representative Signature) _____ Date: _____

(Please Print Patient Name) _____ DOB: ___/___/____