Center For Physical Therapy & Sports Medicine, PC

Name:	**Preferred Name:**
Address:	**Home Phone #:** ☐ Primary
City:	**Cell Phone #:** ☐ Primary
State: **Zip:**	**Date of Birth:**
	Marital Status:
☐ Male ☐ Female	**Email:** Email appointment reminders? ☐ Yes ☐ No
Emergency Contact:	**Relationship to patient:**
Emergency Home Phone#:	**Emergency Work Phone#:**
How did you hear about us? ☐ Doctor ☐ Website/Social Media ☐ Friend/Family ☐ Returning Patient ☐ Other	**Referring Doctor:** **Primary Care Doctor:**

EMPLOYMENT INFORMATION

Employer Name:	**Occupation:** ☐ Student ☐ Retired
Employer Address: **City:** **State:** **Zip:**	**Work Phone #:**

INSURANCE INFORMATION

Are you the policy holder? ☐ Yes ☐ No – Patient's relationship to subscriber: ☐ Spouse ☐ Child ☐ Other	
Policy holder name (unless self):	**Policy holder date of birth:**
Address: **City:** **State:** **Zip:**	**Home phone #:**
Do you have additional insurance? ☐ Yes ☐ No	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to this facility. I understand that I am financially responsible for any balance. I also authorize Center for Physical Therapy & Sports Medicine or the insurance company to release any information required to process my claims.

Patient or Guardian's Signature	**Date**

Patient Name:		Date of Birth:	

RELEASE OF INFORMATION

☐ **I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:**

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

☐ **Information may not be released to anyone.**

The Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call: ☐ **I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:**

Please call:	If unable to reach me:
☐ Home ☐ Work ☐ Cell	☐ you may leave a detailed message ☐ please leave a message asking me to return your call ☐ Other: _____
The best day to reach me is: ☐ Mon ☐ Thurs ☐Tues ☐ Fri ☐ Wed	The best time of day to reach me is: ☐ Morning ☐Afternoon

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Our Notice of Privacy Practices Provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our Notices, you may obtain a revised copy.

I have received a copy of the Notice of Privacy Practices. I understand that I may ask questions if I do not understand any information contained in the Notice.

_____ _____

Patient or Guardian's signature Date

Patient Name:		Date of Birth:	

FINANCIAL POLICY

Thank you for choosing us. We are committed to your health and to offering exemplary service. The following is a statement of our Financial Policies. We require all patients, to read and sign this document prior to treatment being rendered.

I authorize Center for Physical Therapy and Sports Medicine, P.C., to apply for benefits on my behalf for covered services rendered. I request payment from Medicare, and/or any insurance company, to be made directly to the above-named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or the above-named carrier at any time, in writing.

Insurance

We require co-payments be made at the time of service. We will bill your insurance company as a courtesy to you. In order for us to properly file your claims, we must have the most up-to-date information regarding your insurance coverage. For this reason, you may be asked to present your insurance card(s) at each visit. I hereby authorize my insurance benefits to be paid directly to the Center for Physical Therapy and Sports Medicine, P.C. and acknowledge that I am financially responsible for any unpaid portion of my bill. If payment is issued to me directly, I will be responsible for payments of all charges within 30 days.

Missed or Cancelled Appointments

Appointments should not be missed without prior notification. Unless cancelled at least 2 hours in advance, our policy is to charge a fee of $45 for a missed appointment, and notify your attorney or worker's compensation case manager, if applicable.

Returned Checks

In the event that a check is returned for insufficient funds, a $25 returned check fee will be added to your account.

Collection Fees

In the event that your account becomes delinquent, I will be responsible for all cost of collection including administrative charges and attorney's fees of 33.3% plus court costs and interest at the rate of 18% annually.

Self-Pay Patients

The daily rate for Physical Therapy not covered by an insurance carrier is $100 for the initial evaluation and $80 per follow up visit. Payment is due at time of service.

Patient Responsibilities

I understand that I am responsible to notify Center for Physical Therapy and Sports Medicine if I have had previous physical therapy treatments at another facility. This could affect your insurance coverage, due to limitations on allowed visited per year. Your responsibilities as a patient:

- Inform us or any changes to your insurance coverage
- We will handle authorizations for coverage, but may reach out to you for help, if needed
- Obtain referrals from your PCP, if required
- Payment for services. Due at the time of service. Any service not covered by insurance is your responsibility.
- Ask questions about anything you don't understand

_____ _____

Patient or Guardian's Signature Date

Center for Physical Therapy & Sports Medicine, PC

3920 Springfield Road
Richmond, VA 23060
804-747-7472

1011 Hioaks Rd, Ste A
Richmond, VA 23225
804-523-4634

Patient Medical History

Please put an **X** in each box that applies to you…

Have you or any immediate family member ever been told you have:

	None	Self	Family
Cancer?			
Diabetes?			
High Blood Pressure?			
Heart Disease?			
Angina/chest pain?			
Stroke?			
Osteoporosis?			
Osteoarthritis?			
Rheumatoid Arthritis?			

In the past 3 months, have you had or do you experience:	No	Yes
A change in your health?		
Nausea/vomiting?		
Fever/chills/sweats?		
Changes in appetite?		
Changes in bowel or bladder function?		
Shortness of breath?		
Dizziness?		
Unexplained weight change?		

Do you have a history of:	No	Yes
Allergies/asthma?		
Headaches?		
Sexually transmitted disease?		
Seizures?		

Are you currently:	No	Yes
Pregnant?		
Depressed?		
Under stress?		

Current Weight: _____ **Height:** _____

Please list any surgeries and surgery dates:

Surgery	Date

Date of last physical examination with your doctor: _____

Do you or have you in the past smoked tobacco?
YES NO

Do you drink alcoholic beverages?
YES NO

Have you fallen more than 2 times in the past year?
YES NO

Please list any other medical conditions not previously listed: _____

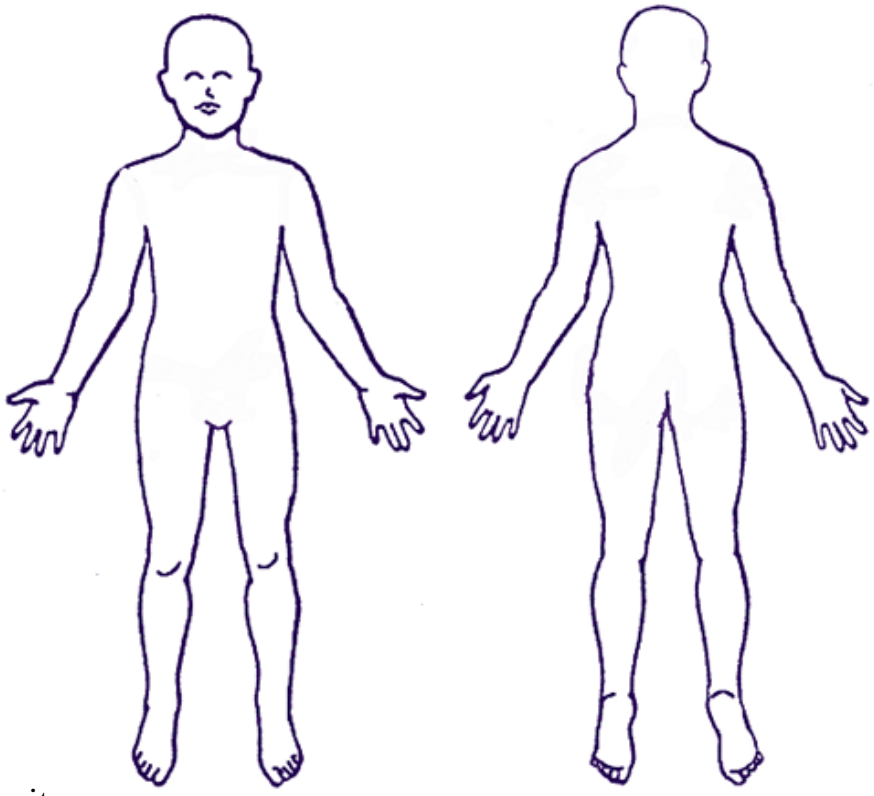
Medications	Dosage	Frequency

Patient Name: _____ Date: _____

Center for Physical Therapy and Sports Medicine, PC

OOO- Pins
XXX- Numbness
////////- Pain
= = = - Other

Use the symbols above to describe the location and type of pain or unusual feeling you are having by drawing them on the pictures.



Average Pain Intensity:

Pain level last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Pain level at its *worst*: *no pain* 0 1 2 3 4 5 6 7 8 9 10 *worse pain*

Pain level at its *best*: *no pain* 0 1 2 3 4 5 6 7 8 9 10 *worse pain*

What is your MAIN complaint or reason for coming to physical therapy?

_____

When did your injury/pain occur? _____

How did your injury/pain occur? _____

Are your symptoms:	☐ Getting worse	☐ The same	☐ Improving
How are you able to sleep at night?	☐ Fine	☐ Moderate difficulty	☐ Only with medication
My symptoms are worse in the:	☐ Morning	☐ Afternoon	☐ Evening
My symptoms are best in the:	☐ Morning	☐ Afternoon	☐ Evening

Patient Name: _____ Date: _____