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THERAPY & SPORTS MEDICINE

Medical History Questionnaire

Name: _____ DOB: _____

Referring Physician: _____ ☐ Self Referred/ Direct Access

Reason for seeking Physical Therapy: _____

How did your injury/condition occur? _____

Accident/Injury onset date (or best guess): _____

Have you had any x-rays, MRIs etc.? Results: _____

Have you had surgery for this injury? YES or NO Type/date of Surgery_____

List any medications you are presently taking (if any):

_____

What best describes your pain: *sharp* *dull* *aching* *shooting*
What best describes your symptoms: *constant* *variable* *occasional (not every day)*

Pain Scale: With zero being no pain and 10 being the worst pain (needing an ambulance),

What number has your pain been in the past week (0-10):

At Worst _____ Currently _____ At Best _____

What activities make your pain/symptoms worse? _____
(examples: Sitting, Lying, Reaching, Standing, Walking, Bending, Lifting, Driving, Dressing)

What relieves your pain/symptoms? _____
(examples: rest, ice, medication, positioning)

Circle any of the following conditions you have or have had:

Asthma, Bronchitis or Emphysema	Tuberculosis	Shortness of breath
Vision or hearing difficulty	Heart disease	Numbness/tingling
Dizziness or fainting	High blood pressure	Pacemaker
Blood clot (DVT)	Stroke/TIA	Epilepsy/Seizures
Currently Pregnant	Allergies	Anemia
Bowel or bladder problems	Diabetes	Infectious diseases
Cancer	Arthritis	Osteoporosis
Sleeping problems/difficulties	Emotional/psychological problems	

Other relevant past medical or orthopedic history that would assist us in your care:

_____

What are your expectations/ goals while in this program? _____

Signature: _____ Date:_____
Patient/Guardian

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Patient Information

HOW DID YOU HEAR ABOUT OUR CLINIC? (Check all that apply)

Doctor _____ Website/Online _____ Family/Friend _____ Other_____

Name of person who Referred you_____

PLEASE PRINT

Patient Name: _____ Gender: M F

Date of Birth: _____ Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ (W): _____ (C): _____

Emergency Contact: _____ Relationship:_____ Phone:_____

Employed (where):_____ Student (where):_____

If patient is under the age of 18 yrs, parent/guardian info MUST be provided here:

Insured Party's Full Legal Name: _____ Relationship to patient: _____

Date of Birth:_____ Phone (H):_____ (C): _____ (W):_____

CANCELLATION/ATTENDANCE POLICY

We pre-schedule 3 to 4 weeks in advance. Patients who need to cancel appointments must call more than 24 hours prior to their scheduled appointment so that we are able to offer this slot to other patients. Cancellations with less than 24 hours' notice are subject to a $25 cancellation fee. Patients who Cancel 3 times or No Show 2 times are *subject to discharge*. As a courtesy to other patients, we may refuse treatment to patients that arrive more than 15 minutes past their appointment time.

CONSENT FOR PHYSICAL THERAPY CARE AND TREATMENT

I do hereby agree and give my consent for MVP Therapy and Sports Medicine (MVP Therapy) to furnish physical therapy care and treatment as considered necessary and proper in evaluating and/or treating his/her physical condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, DMAS, private insurance and third party payers, to MVP Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment. Further, MVP Therapy reserves the right to make changes to our privacy policy at any time in order to remain in compliance with State and Federal regulations.

HIPAA

I have been provided with a current copy of the Health Insurance Portability and Accountability Act (HIPAA) for patient Privacy and Security, and understand its contents.

FINANCIAL POLICY AND STATEMENT

We bill your insurance carrier as a courtesy to you. However, it is not a guarantee of payment. Benefits are determined at the time the claim is processed. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment or your estimated share be made today. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit it to MVP Therapy.

- The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.
- I understand and agree that my account, if paid within 30 days of my discharge will be interest free, after 30 days my account will be subject to an 18% interest (APR). **If I fail to make any payments for which I am responsible in a timely manner, I will be charged an extra collection fee (30% of the owed balance) of monies owed, including court costs, collection agency fees, and attorney fees.**
- **I understand and agree there will be a $35 service charge for all returned checks.** If I have indicated paid in full or similar endorsement on my check and a balance remains on my account, I agree that this remaining balance is still my responsibility.
- I understand that MVP Therapy will bill my insurance carrier for services rendered. I am responsible for providing MVP Therapy with my most current insurance information
- Prior to treatment I will notify MVP Therapy of any changes in my insurance that may occur.
- NOTE: Estimated insurance benefit information is provided as a courtesy to our patient, but is not intended to release them from total responsibility for their account balance. The above information has been read by and explained to me.

CO-PAYMENT, CO-INSURANCE and/or DEDUCTIBLE

We will contact your insurance company to verify coverage and your co-pay, co-insurance, and/or deductible amounts. If your policy stipulates that you are responsible for making any of these payments, MVP Therapy is contractually obligated to collect those payments. We require payments to be made at the time of service.

I HAVE READ ALL OF THE ABOVE, AND UNDERSTAND MY RESPONSIBILITY AS A PATIENT OF MVP THERAPY AND FOR THE PAYMENT OF MY ACCOUNT

Signature:_____ **Date:**_____ **MVP Staff Witness:** _____

Patient/Guardian/Responsible Party