MIDLOTHIAN VILLAGE PHYSICAL THERAPY

PATIENT INFORMATION

**How did you hear about our clinic? (Check all that apply)

Doctor _____ Website _____ Phone Book _____ 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:_____

Payment Arrangement: Insurance Self Pay Workers Compensation Personal Injury/Attorney

Marital Status: Single Married Divorced Widowed

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

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy holder's Name, if different: _____Date of Birth: _____Relationship: _____

Secondary Insurance: _____

Policy#:_____ Group #: _____

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

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

Address:_____ City:_____ State: _____Zip: _____

Date of Birth:_____ SS#:_____Phone (H):_____ (C): _____(W):_____

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Medical History Questionnaire

Name: _____ DOB: _____

Referring Physician: _____

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_____

Have you had Outpatient Physical Therapy for this injury? Yes / No

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): _____

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

MIDLOTHIAN VILLAGE PHYSICAL THERAPY

CONSENT FOR PHYSICAL THERAPY CARE AND TREATMENT

I, the undersigned, do herby agree and give my consent for Midlothian Village Physical Therapy to furnish Physical Therapy care and treatment to _____, as considered necessary and proper in evaluating and/or treating his/her physical condition.

Signature:_____ Date:_____
Patient/Guardian (please circle one)

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, 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 anytime in order to remain in compliance with State and Federal regulations.

Signature:_____ Date:_____
Patient/Guardian (please circle one)

HIPPA

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

Signature: _____ Date: _____

FOR OFFICE USE ONLY: Insurance Verification

Referring Physician:_____ Phone:_____ Fax:_____

NPI #:_____ Prescription Date:_____

Primary Care Referral Needed? Y / N PCP:_____ Phone:_____

Number of visits authorized:_____ Start Date:_____ Expiration Date:_____

Co-pay:_$_____(per visit) Co-Ins: _____% Deductible:_%_____ Diagnosis/ICD-9 Code(s):_____

Max Visits Allowed:_____ Number of visits ordered:_____

Primary Insurance:_____ Phone:_____ Spoke with:_____

Policy or WC claim #: _____ Group #: _____

Authorization #: _____ Total visits approved_____ Date range _____

Other comments: _____

Billing Address:_____City:_____State:_____Zip:_____

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FINANCIAL POLICY 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 collecting 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 coverage 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.

CANCELLATION/ATTENDANCE POLICY

We pre-schedule two to three 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. **Appointments cancelled with less than 24 hours notice are subject to a $25 fee.** Patients who "No Show" for more than one appointment are subject to a **$25 "No Show" fee for each missed appointment**. As a courtesy to other patients, we may refuse treatment to patients that arrive more than 15 minutes past their appointment time.

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.

SUPPLY POLICY

With the exception of Workman's Compensation and Medicare/Medicaid, MVP Therapy does not bill insurance companies for supplies. If your physician and your therapist deem that it is medically necessary for you to be issued any Durable Medical Equipment (DME) or other supplies, you will be required to pay for the equipment or supplies at the time that it is issued. You will be provided with a receipt and, if applicable, a copy of your physician's prescription for the equipment or supplies which you may then submit to your insurance company directly for reimbursement.

I HAVE READ THE ABOVE, AND UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

Signature:_____ **Date:**_____

Patient/Guardian/Responsible Party

Signature:_____ **Date:**_____

MVP Therapy Representative/ Witness