VITAL PHYSICAL THERAPY LLC

Patient Name: ____ Date: _______________
Address:____
City____________________ State______________________ Zip _________________________________
Gender: M or F Email address:____
Date of Birth: ______________________ Social Security number: _________________________________
Marital Status: _____________________ Spouse:____
Home Phone: _____________________ Cell phone: ________________ Work Phone: _________________
Employer: ______________________________ Occupation: ____
Diagnosis: ____ Date of Injury: ______________

Have you had P.T. for this before?: Y or N If yes, when and what service? ______________________________

Referring Physician: ____________________________ Phone #: ____

Primary Care Physician: __________________________ Phone #: ____

How did you hear about us? Doctor referral Search engine: _________ Our website Family member/friend
Specific Site?

INSURANCE INFORMATION – Please complete entire section

Insurance Carrier: __________________________________ Phone #: _______________________________
Policy #: ____ Group #: _______________________________
Name of Subscriber to Policy: _____________________________ Date of Birth: _________________________
Relationship to Subscriber: (Please circle) Self /Spouse /Parent/Child /Guardian Other
Subscriber Address (if different than
Patient):____

Secondary Insurance Carrier: ____
Policy #: ____ Group #: ________________________________
Subscriber: _______________________ Date of Birth: _____________ Relationship: ___________________

****If you have MEDICARE, are you also receiving care from a Home Health Agency? Y or N**
Agency Name: _______________________________________ Phone #:______________________________

If your injury is Work or Motor Vehicle Related, you MUST complete this section:
Is your injury work related?: Y or N Is your injury related to a motor vehicle accident?: Y or N
Date of Injury/accident: ______________________________
Work/Auto Insurance Carrier: ____
Adjuster Name: ____
Claim #: ________________________________ Adjuster's Phone #: ___________________________________
Insurance Co Billing Address: ____
Street City/State/Zip

Please read and sign below.

1. I hereby assign to Vital Physical Therapy LLC all payments for medical services rendered to myself and/or my dependents.

2. Referrals are the responsibility of the patient to obtain from their Primary Care Physician. In certain instances insurance approvals are the responsibility of Vital Physical Therapy LLC to obtain (24 hours from your first visit in some cases). I understand that I must promptly provide accurate insurance information as defined by my insurance policy. In the event that Vital Physical Therapy LLC is unable to follow contract guidelines with my insurance carrier based on inaccurate and/or untimely-provided insurance information, I understand that I will be responsible for payment at the rate my insurance carrier would have paid.

3. I understand that I am financially responsible for charges not covered by my insurance carrier.

4. If my injury is *work or auto related*, I understand that I must inform Vital Physical Therapy LLC and provide all accident and claim information prior to receiving treatment. The front of this form must be completed in its entirety. I also understand that if my case proceeds to litigation, Vital Physical Therapy LLC will not be required to wait longer than three months for payment. In the event three months lapses from the date of services I will pay Vital Physical Therapy for services rendered and seek reimbursement from my settlement proceeds.

6. I understand that I must provide Vital Physical Therapy LLC with 24-hour notice in cancelling or rescheduling an appointment. Failure to provide 24-hour notice will subject me to a $40 fee. If I no show to my appointment, I will be subjected to a $50 fee.

7. I have received Vital Physical Therapy LLC **NOTICE OF PRIVACY PRACTICES** and **POLICY DISCLOSURE**. I understand my responsibilities regarding applicable fees and I agree to comply with the terms of the Policy Disclosure.

Signature: ________________________________

Name Printed:___________________________________ ***Date:***____________________

If the patient is a minor a signature from the parent or guardian is required.
Guardian name____________________ ***Signature***________________________***Date:***________________________

Person to notify in case of emergency. College students should fill in your home address/parent's address.

Name: _________________________________**Relationship:**________________________________
Address: ____
Home Phone #: _____________________________**Work Phone #:**____________________________

Medical History

Thank you for taking the time to fill out this questionnaire in regards to your current and past medical history. Please answer accurately and completely. The answers you supply will help us to determine the best course of treatment for you. We appreciate your cooperation.

1. Injury/Diagnosis:________________________________

2. Date of Injury _________ Date of Surgery:___________

3. Briefly describe your current injury____
____

4. Which position or activity makes pain worse? And which makes it better?
____

5. Grade your pain: On a scale of 0-10, 0 being no pain and 10 excrutiating pain. Please give your current pain a score___________________

6. In regards to your current condition, please indicate the date (if known) of your doctor's visit:

Most recent: ___________ Next visit: _________

7. Have you had recent diagnostic testing for this injury (i.e. xrays/MRI/ CT scan)?

Yes or No Date: _____________
If YES, please note which test and results (if known):
____

8. Are you presently working? Yes No Has your position been modified? ________

9. Describe what, if any, limitations you are experiencing as a result of injury/pain??____

10. Are you currently exercising and/or participating in sports? Yes No

11. Please indicate all of the following conditions that apply, either presently or in the past:

___ High blood pressure
___ Gout
___ Varicose vein
___ Currently pregnant
___ Epilepsy/Seizure
___ Stroke
___ Dizziness or fainting
___ Cancer
___ Recent Infection, specify________
___ Other: _______________

___ Chronic obstructive pulmonary disease
___ Emotional/Psychological
___ Angina, Heart attack
___ Heart surgery, Date _____
___ Arthritis
___ Diabetes
___ Pace maker
___ Skin Disease
___ Allergies, specify _____________Skin Disease

12. Please list any prior surgeries you think may affect your treatment program:
____

____

13. Are you currently taking medication(s)? _______________________

If so, please list them below:

Name: ___________________________ Signature:___________________________ Date:______________

CONSENT TO TREATMENT

I, the undersigned, a patient at Vital Physical Therapy LLC, do hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.
I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that Vital Physical Therapy LLC will prepare insurance forms, and will bill only as a courtesy my insurance company directly. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

By signing below you are agreeing to all the terms and conditions.
Patient signature: ____
Legal Guardian signature: ____
Date: ______________________