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?____

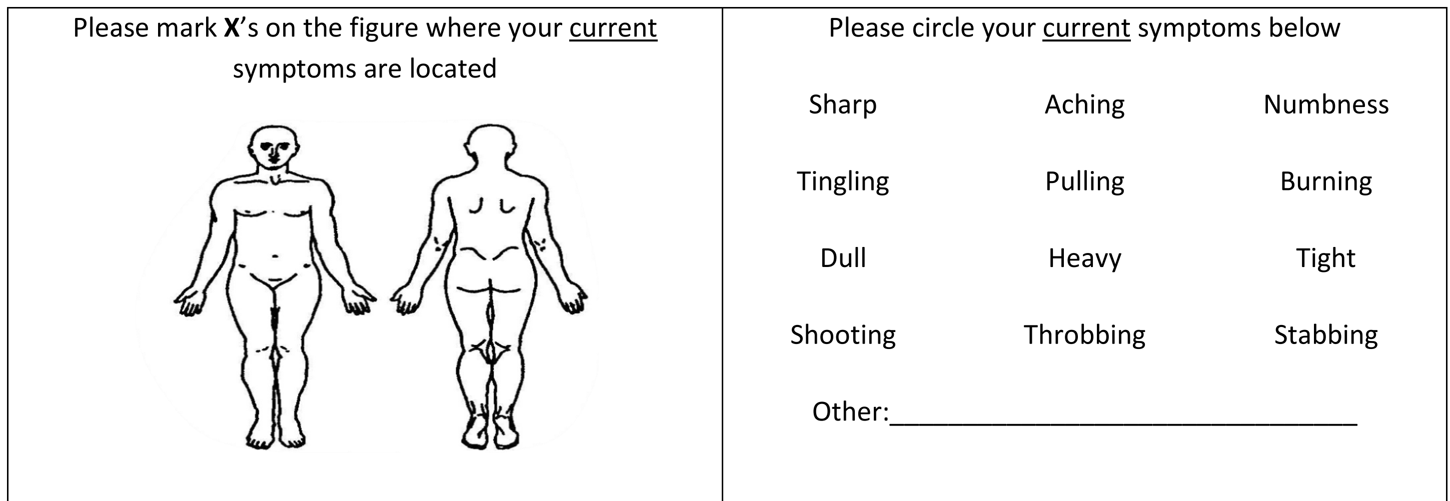
What makes your pain increase?____

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)



Please mark **X**'s on the figure where your current symptoms are located	Please circle your current symptoms below		
	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**

			Please specify any work restrictions given to you by your doctor
Are you currently working?	YES	NO	______________________________________
Do you have any work restrictions?	YES	NO	______________________________________

Please list any specific limitations you have due to your current symptoms

At Home: ____

At Work: ____

At Leisure: ____

MEDICAL HISTORY

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
Allergies	☐Yes ☐No	Dizzy Spells	☐Yes ☐No	Metal Implants	☐Yes ☐No
Anemia	☐Yes ☐No	Emphysema/Bronchitis	☐Yes ☐No	MRSA	☐Yes ☐No
Anxiety	☐Yes ☐No	Fractures	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Arthritis	☐Yes ☐No	Fibromyalgia	☐Yes ☐No	Muscular Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Gallbladder Problems	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Auto Immune Disease	☐Yes ☐No	Headaches	☐Yes ☐No	Parkinsons	☐Yes ☐No
Cancer	☐Yes ☐No	Hearing Impairment	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Cardiac Conditions	☐Yes ☐No	Hepatitis	☐Yes ☐No	Seizures	☐Yes ☐No
Cardiac Pacemaker	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Smoking	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Speech Problems	☐Yes ☐No
Circulation Problems	☐Yes ☐No	HIV/AIDS	☐Yes ☐No	Strokes	☐Yes ☐No
Currently Pregnant	☐Yes ☐No	Incontinence	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Depression	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Diabetes	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Vision Problems	☐Yes ☐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:_________________________

2019 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, 2019, out-patient Physical and Speech (combined) and Occupational Therapy each have a maximum allowable of $2040.00 per year. This allowable may be extended if the injury or illness falls under the cap exception set-up by Medicare and is deemed medically necessary.

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 2019. _________

HOME HEALTH QUESTIONAIRE

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): ____/____/______

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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.

____ Date: _____________________________

(Patient or Representative Signature)

____ DOB: ________/_______/____________

(Please Print Patient Name)