MONTCLAIR PHYSICAL THERAPY
3767 Fettler Park Drive, Dumfries, VA 22025
Phone: *(703) 730-6400* | Fax: *(703) 730-9212*

BODY WORKS PHYSICAL THERAPY
2701 Neabsco Common Place #114, Woodbridge, VA 22191
Phone: *(703) 897-4800* | Fax: *(703) 897-1078*

PATIENT INFORMATION *(please print clearly)*

Are you a: ☐New Patient ☐Returning Patient ☐ Existing Patient – Information has changed during treatment

If you are returning, has any info changed since your last visit? ☐Yes ☐No If yes, please provide **ONLY** the new info.

Name: _____ Social Security #: _____
Last *First* *MI*

DOB: _____ Age: _____ Gender: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Work#: _____ Primary Contact ☐ Referring Doctor: _____

Home#: _____ ☐ Brief description of the injury/how symptoms occur:

Cell#: _____ ☐

Email: _____ ☐ _____

Is your injury a result of: ☐Workers Comp ☐Auto Accident ☐Other Date of Injury: _____ State: _____

How did you hear about us: ☐MD ☐Insurance ☐Internet/Facebook/Yelp ☐Advertisement ☐Friend ☐Other

EMERGENCY CONTACT

Contact: _____ Relationship: _____

Phone #: _____ Alternate Phone #: _____

PATIENT'S EMPLOYMENT

Employer: _____ Occupation: _____

Address: _____

Work Status: ☐Full-time ☐Part-time ☐Leave of Absence ☐Not Employed Are you a student? ☐Yes ☐No

INSURANCE

Primary Insurance: _____ Member ID# _____ Group# _____

Subscriber: _____ Relationship: _____ SS#: _____ DOB: _____

Secondary Insurance: _____ Member ID# _____ Group# _____

Subscriber: _____ Relationship: _____ SS#: _____ DOB: _____

WORKER'S COMPENSATION *(if applicable)*

Insurance Carrier: _____ Phone#: _____

Claim #: _____ Address: _____

PAST MEDICAL HISTORY

Please briefly describe any medical conditions or pertinent information regarding your past medical history:

Are you pregnant? ☐ Yes ☐ No ☐ Not Applicable

Do you have any allergies? ☐ Yes ☐ No If yes, please list below.

Have you received previous treatment for this issue? ☐ Yes ☐ No
If yes, please explain (eg: surgery, hospitalization, PT, injections, etc):

Are you currently being treated by any other physician or therapist? ☐ Yes ☐ No
If yes, please list their name & condition being treated.
1)
2)
3)
4)

Have you had any of the following diagnostic tests for this issue? (Check all that apply)
☐ x-ray ☐ MRI ☐ CT scan ☐ EMG
☐ Other: _____
Results: _____

Have you recently noted: (Check all that apply)

☐ Unexpected weight loss? ___ lbs	☐ Fever /Chills / Night Sweats	☐ Other: _____
☐ Unexpected weight gain? ___ lbs	☐ Numbness / Tingling	
☐ Nausea/Vomiting	☐ Fatigue	
☐ Loss of Appetite	☐ Weakness / Lethargy	

Do you have/ have you had any of the following problems? (Check all that apply)

YES	NO		YES	NO	
☐	☐	Chest pain	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Respiratory Problems
☐	☐	Fainting	☐	☐	Seizures
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	Heart Attack	☐	☐	Surgeries (list below)
☐	☐	Metal Implants	☐	☐	Other health conditions (list below)

If YES to any of the above, please list/explain:
_____

Have you ever had surgery? ☐ Yes ☐ No If yes, please briefly explain and give the date(s).

Are you presently taking any medication(s)? ☐ Yes ☐ No
If yes, please list below. If you need more space, a separate sheet/form is available.

Current medications & conditions for which they are taken:
(Please include prescriptions, over the counter medicines, vitamins, minerals/herbal supplements, dietary/nutritional supplements)

Drug name	Dosage (how much)	Frequency (how often)	Route (oral/topical/inhalation/etc)

BODY PAIN SCALE

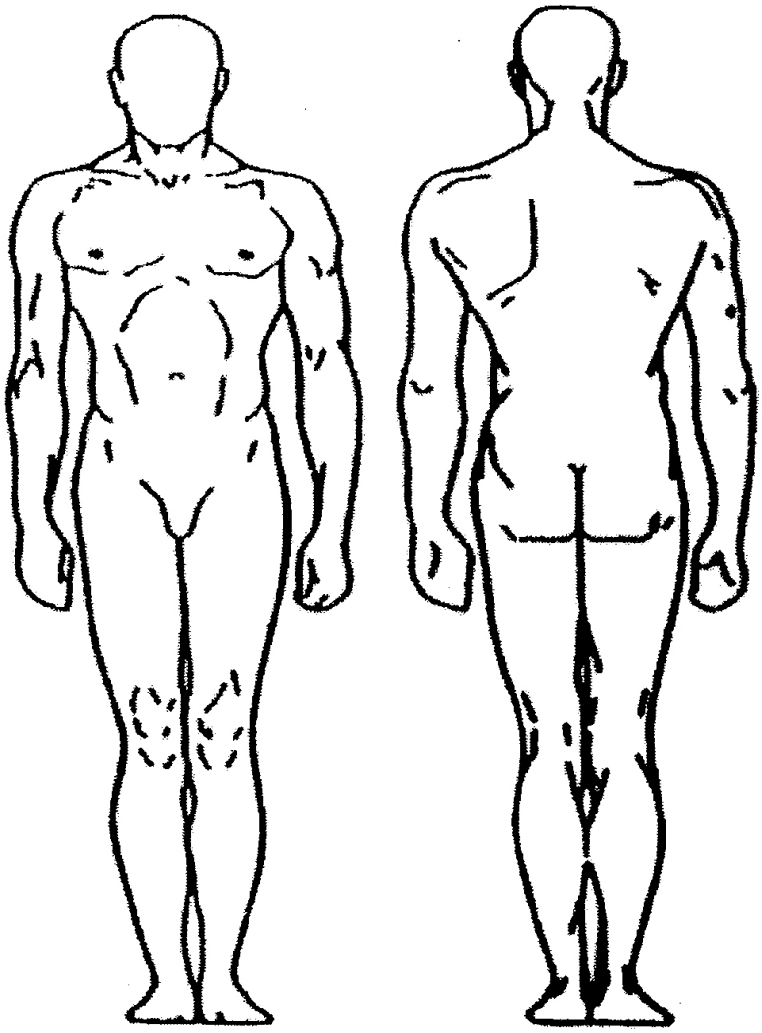
Pain Rating Scale: Use the number scale that is listed below to describe the **INTENSITY** of your pain.

NO PAIN	LOW			MEDIUM			HIGH			SEVERE
0	1	2	3	4	5	6	7	8	9	10

Using the number rating system above, describe your:

	Pain level **NOW**:	(0-10)
In the past 30 days	Pain level at **BEST**:	(0-10)
In the past 30 days	Pain level at **WORST**:	(0-10)

RIGHT **LEFT** **LEFT** **RIGHT**



Use the symbols listed below to describe the location & type of pain or unusual sensation(s) you have by marking on the body diagram(s) above.

OOOO	Pins & Needles
XXXX	Numbness
//////////	Pain
=====	Other

CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I understand that the previous page's information is necessary to provide me with rehabilitation treatment in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have Montclair Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.

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 to my insurance carrier in order to determine benefits to which I may be entitled.

I acknowledge the review and/or receipt of the therapist's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

PATIENT AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize Montclair Physical Therapy to apply for benefits on my behalf for services rendered by them, and request payment from my insurance carrier be made directly to Montclair Physical Therapy.

Either my insurance carrier or I may revoke this authorization at any time in writing. I permit a copy of this authorization to be used in place of the original.

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

The services you have elected to participate in imply a financial responsibility on your part. You are responsible for payment of your deductible and co-payment / co-insurance as determined by your contract with your insurance carrier. All co-payments must be paid at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved time period, you will be responsible for your account balance in full.

DELINQUENT ACCOUNTS: Should your account become delinquent, you will be responsible for all collection costs and 33 1/3 of the principal amounts in attorney fees.

RETURNED CHECK FEE: I, the undersigned, agree to pay a fee of $25.00 for any check returned by my financial institution regardless of reason.

REFERRALS / AUTHORIZATIONS: Some managed care plans require written authorization forms from your primary care physician for each visit to a specialist. It is the patient's responsibility to make sure that Montclair Physical Therapy has a valid authorization form before each visit. <u>These forms cannot be issued retroactively</u>. Failure to obtain authorization may drastically reduce your benefits/coverage with your insurance carrier.

APPOINTMENTS: All appointments should be scheduled in advance and 24-hour notice is required for cancellations. Patients who are more than fifteen (15) minutes late for a scheduled visit may not be seen depending on the discretion of the therapist. The patient may be rescheduled for a future visit if not seen. <u>There is a $25 fee charged for all NO SHOW / NO CALL visits as well as SAME DAY CANCELLATIONS.</u>

I certify that I have read the above policies (i.e., Consent to Treatment and Authorization to Release Information; Patient Authorization for Direct Payment; and Statement of Financial Responsibility) and herby give consent to each.

I understand that I may request a copy of this agreement at any time.

Signature: _____ Date: _____

Printed Name: _____