Please explain how you heard about us?

SOURCE ONE Village Physical Therapy

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Patient Information

Name (Last, First, MI)			**Date**
Street Address	**City**	**State**	**Zip Code**
Home Phone ☐ Preferred ( )	**Work Phone** ☐ Preferred ( )	**Cell Phone** ☐ Preferred ( )	
SSN	**Date of Birth**	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered ☐ Other _____
Employer	**Work Phone**	**Email Address**	

Accident Info

Were you in an accident? Yes☐ No☐ WC ☐ Auto ☐ Personal Injury _____	**If yes, please describe**	Date of Accident:_____ Are you under LOP?_____

Do you have PIP? Yes☐ No ☐ Claim #_____ IF yes, Adjuster Name and #: ___

Attorney Name: _____ Phone:_____ Contact person:_____

WC Injury: Adjuster Name: _____ Phone:_____

Financially Responsible Party

Is the patient the responsible party/guarantor? ☐ Yes ☐ No (Please complete guarantor's information below)

Primary Insurance Company	**Policy #**	**Group #**	**Subscriber's SSN**
Name of Subscriber (if other than patient)	**Employer of Subscriber**		**Date of Birth**
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		**Gender** ☐ Male ☐ Female	**Phone** ( )

Emergency Contact

Emergency Contact Name		**Relationship to Patient**
Home Phone ☐ Preferred ( )	**Work Phone** ☐ Preferred ( )	**Cell Phone** ☐ Preferred ( )

Referral Info

Referring Physician's Name	**Physician's Phone # / Fax #** (if known) ( )

PCP Info

Primary Care Physician ☐ Same as Referring Physician above	**Physician's Phone # / Fax #** (if known) ( )

ELECTRONIC APPOINTMENT REMINDERS

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments. Where would you like to receive appointment reminders? (Check desired reminder(s) and list contact information) Please indicate if you would like Spanish Text by circling Espanol.

Email _____ Text Message/ Espanol _____ Voice Message/Espanol_____

Appointment information is considered to be "Protected Health Information" under HIPAA. By my initials, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

X____(Initial) do NOT want Source One to send me electronic appointment reminders.

By signing below, I acknowledge that the information I provided is correct to the best of my ability. I hereby authorize Village Physical Therapy, Source One Rehab and its staff to use and disclose my personal health information, as necessary, for the purpose of obtaining medical treatment, facilitating the payment from third party payors for treatment and for normal business.

Patient's Signature _____ **Date** _____

Staff Initials:_____

Name:_____ **Date:**_____

****It is essential that you provide accurate, comprehensive and truthful information. Some physical therapy modialities are not appropriate for all patients due to certain medical conditions. ****

Is your current condition due to an injury or accident?_____ **If yes, describe**:_____

When did this problem start?_____ **Average pain level**:(1-10)_____***10 being worst pain imaginable***

Have you had any of the following tests for this condition? XRAY ☐ MRI ☐ CT ☐ INJECTIONS EMG

Does your pain interfere with routine activities: ☐ sleep ☐ work driving ☐ reaching ☐ exercise ☐ housework ☐ hobbies _____other

Are you working?_NO __YES **Occupation**?_____ **Job demands**:☐sitting ☐standing ☐bending/lifting ☐computer work ☐ reaching ☐climbing ☐stooping/crouching ☐ crawling ☐ other _____

Have you RECENTLY noted any of the following (check all that apply)?

❑ difficulty maintaining balance while walking ❑ headaches ❑dizziness/lightheadedness ❑ shortness of breath

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ anemia	❑ heart disease	❑ Parkinson's disease	❑ History of DVT? If yes, are you currently experiencing any symptoms; i.e chest pain, dizziness, elevated heart rate, shortness of breath, unexplained leg pain? Yes____ No _____N/A____
❑ asthma	❑ high blood pressure	❑ arthritis	
❑ diabetes	❑ multiple sclerosis	❑ stroke	
❑ epilepsy/seizures	❑ osteoporosis	❑ pacemaker	
❑ cancer	❑ spinal fusion	❑ spinal cord stimulator	❑ other_____

Height:_____ **Weight:** _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1._____ 2._____ 3._____

Do you drink? YES __ NO __ Drinks/Week_____

Do you smoke? YES NO _____ pack/day

Active hobbies? _____

Are you currently taking medications? Yes___ No____

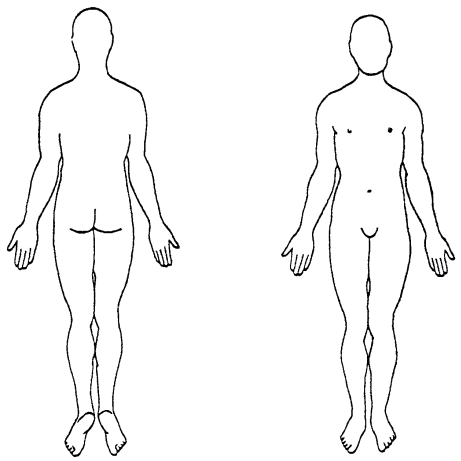
Please list current medications:_____

❑ See Attached

ALLERGIES:

_____

Please mark the location of your pain



What is your goal for therapy at this time?_____

Patient Signature:_____ **Date:**_____

SOURCE ONE

Village Physical Therapy

Financial/Office Policy

Thank you for choosing us for your healthcare needs. We are committed to providing you with quality and affordable healthcare. The following is our financial policy. Please read it, ask us any questions that you may have, and sign the attached signature page. A copy will be provided at your request.

____ Initial **Patient Responsibility:** We participate in many insurance plans. We suggest you become familiar with your insurance benefits and confirm our participation with your plan. Most misunderstandings about insurance can be avoided if you understand what your policy covers. Please contact your insurance company with any questions you may have regarding your coverage. Pursuant to our participation with your insurance plan we are required to collect co-pays, deductibles, and coinsurance at the time of service. **These fees cannot be waived**. We accept cash, checks, Debit Cards, MasterCard, Visa, American Express, and Discover.

____ Initial **Third Party Liability:** I agree that payment for services rendered is not contingent upon any settlement judgment or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered in the event that a settlement is not reached or if my case is dropped by my attorney and I fail to contract with other legal counsel.

____ Initial **Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid driver's license and a current, valid insurance card. We may be required to collect payment in full if we are unable to verify your current insurance information. Please bring these items with you to each visit.

____ Initial **Claims submission:** If we are contracted with your insurance company, we will file your claims for you. Your insurance may require additional information from you in order to process the claim. Failure to comply with their request within 30 days will result in full patient responsibility for the claim. Please be aware that due to the length of time that is required to process payments it may be several months before you receive a statement for services.

____ Initial **Non-payment:** Unpaid accounts will be referred to an outside collection agency and will result in dismissal from the practice.

____ Initial **Returned Checks:** There will be a $25 fee for all returned checks.

____ Initial **No shows/ Cancellation Policy:** As a courtesy to our staff and other patients we ask that you keep your scheduled appointments. If you are unable to attend a scheduled appointment, please call and cancel at least two (2) hours prior to the appointment. Failure to cancel the appointment within the time frame will result in the assessment of a fee in the amount of $15 per incidence. **A missed Saturday appointment without cancellation notice will result in the assessment of a fee in the amount of $50 per incidence.**

ASSIGNMENT of BENEFITS

____ Initial **I authorize direct payment to be made to SOURCE ONE/VILLAGE PHYSICAL THERAPY, for any and all medical rendered. I hereby assign all of my right, title, and interest, to SOURCE ONE/VILLAGE PHYSICAL THERAPY of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of SOURCE ONE/VILLAGE PHYSICAL THERAPY customary charges for the services provided.**

_____ _____

Print Patient Full Name Date

_____ _____

Patient/Guardian Signature Date

CONSENT for TREATMENT

_____ **Initial** I acknowledge that the purpose of the care, reasonable alternative forms of therapy, risks of the recommended and alternative care and the risks of foregoing this care have been fully explained to and understood by me. I recognize that the practice of therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy. I also recognize that therapy care may involve the touching of my body by Therapist or other members of the Clinic's professional staff and that full or partial disrobing may be required to facilitate such care, all of which is expressly consented to by me. I agree to cooperate fully and to participate in all therapy care procedures, to comply with the plan of care as it is established and to pay Clinic's charges for such care upon my receipt of Clinic's invoice for such care. I have read the above and I certify that I have had an opportunity to discuss the contents thereof to my satisfaction. By initialing, I am hereby consenting to the therapy care described above, to be performed by Therapist or other members of Clinic's professional staff, as determined by Therapist from time to time.

HIPAA

_____ **Initial** I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice anytime. I have the right to review the notice prior to signing this consent. I have had the opportunity to receive and review the Notice of Privacy Practices of Source One.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information-Keeping information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient, referring physician, or legal guardian. The following names are people I would like to be involved in or have access to my protected health Information on a routine basis. I give permission for **SOURCE ONE/VILLAGE PHYSICAL THERAPY** to share my protected health information with:

Contact Name	Contact Name
DOB	DOB
Relation to Patient	Relation to Patient

RELEASE of INFORMATION

I hereby authorize **SOURCE ONE/VILLAGE PHYSICAL THERAPY**, to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment.

X _____ (Initial)

CONSENT and AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Consent for treatment, HIPAA Policy and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

Patient Name (Please Print)	Patient Date of Birth
Signature of Patient, Parent, or Legal Guardian	Date

Staff Initials: _____

Source One Therapy: Photograph, Video, and Satisfaction Survey Release

I hereby grant Syzygy and its affiliates permission to the rights of: my image; my likeness and sound of my voice as recorded on audio or video tape; my satisfaction survey responses, without payment or any other consideration. I understand that my image and my responses may be edited, copied, exhibited, published or distributed and I waive the right to inspect or approve the finished product wherein my likeness or satisfaction survey responses appear. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image, satisfaction survey responses, or recording. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

Photographic, audio or video recordings, and satisfaction survey responses may be used but not limited to following: social media and website enhancement, conference presentations, educational presentations or courses, informational presentations, on-line educational courses, educational videos, digital media presentation.

By signing this release, I understand this permission signifies that: photographic or video recordings of me; my satisfaction survey responses, may be electronically displayed via the Internet or in the public educational setting. I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby.

Full Name_____

Phone_____

Email Address_____

Signature_____ Date_____

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date_____

If you do not wish for Syzygy and its affiliates to use your image; your likeness and sound of your voice as recorded on audio or video tape; your satisfaction survey responses; please initial below.

I reserve the right to withhold permission to the rights of my image; my likeness and sound of my voice as recorded on audio or video tape; my satisfaction survey responses.

X_____

Staff Initials: _____