VENTURE PHYSICAL THERAPY / WEST COBB
PATIENT INFORMATION SHEET

Today's Date _____ How did you hear about us? _____

Patient's Name _____ Date of Birth ____/____/____
First Middle Last Mo Day Year

Street Address (No P.O. Box please): _____
Street

_____
City State Zip

Social Security Number _____ Home Phone # (_____) _____
Area code

Cell Phone# (_____) _____ E-mail Address _____
Area code

Marital Status: M S W D Age _____ Sex: M F
(Please circle one) (Please circle one)

Employer: _____ Work Phone: _____

In case of emergency, please contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

_____

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

Responsible Party: _____

Social Security Number: _____ DOB: _____ Relationship to Patient: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell/Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Subscriber's Name: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____ ID #: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Please describe your injury or area of pain for which you are being seen today: _____

Date of Injury? ____/____/____ Was your injury due to an accident? Yes No If yes, was it job related? _____

Injury due to auto accident? YES NO Auto Insurance Information on the vehicle you were in: Carrier _____

Policy Number _____ Claim # _____ Adjuster _____

Adjuster Phone # _____ Please explain how your injury occurred: _____

_____

I certify that the above information that I have given is accurate and true to the best of my knowledge. _____(initial)

CONSENT TO TREAT: I hereby voluntarily consent to receive treatment for my condition according to my treatment plan. I have been informed by my physical therapist of the treatment procedures to be utilized, including information about significant risks, benefits of and alternatives to the procedures and have had my questions answered. I understand this (these) treatment(s) will be performed by an appropriately credentialed staff member employed by or acting as an agent of Venture Physical Therapy West Cobb. I further understand that I may rescind this consent at any time and will be informed of the potential consequences of that decision.

Patient _____ Date _____ Witness _____

VENTURE PHYSICAL THERAPY / WEST COBB

Patient Intake Questionnaire

TODAY'S DATE: _____

NAME: _____

I. CURRENT HISTORY

A. Specifically, what is your present problem or complaint? _____

_____

B. What is the current condition? _____

C. When did this episode begin? Date when problem started: ____/____/____

Date of injury: ____/____/____ Date of surgery: ____/____/____

D. 1. Rate the intensity of your pain: (Circle the underlined words/numbers that are appropriate.)

(no pain) 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

2. Is your pain: Constant or does it Come and go

3. Is your pain getting: Better Worse Not changing

4. Current Activity level: 0%=bedridden 100%=able to perform all pre-injury activities

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

II. MEDICAL HISTORY

A. Circle the underlined words which are appropriate. Do you have any history of:

Heart disease lung disease cancer diabetes arthritis high blood pressure

Mental disorder stomach disorder pacemaker metal implant allergies

Bleeding tendencies major operations serious personal injures other: _____

B. Are you currently or have you recently taken any: steroids (e.g. cortisone)

Muscle relaxants pain killers anti-inflammatories blood thinners other: _____

C. Circle the underlined words that are appropriate. Since the onset of this problem, have you had:

MRI CT Scan X-Rays Injections Nerve Blocks

Bone Scan Chiropractic Treatment Physical Therapy other: _____

D. PLEASE ANSWER THIS QUESTION ONLY IF YOU HAVE COME TO PHYSICAL THERAPY FOR NECK OR BACK PAIN. Circle the underlined words which are most appropriate.
Since the onset of this problem, have you had:

difficulty with control of bowel or bladder function any numbness in the genital or anal area

any dizziness or fainting attacks unexplained weight loss

severe pain while in bed at night fever/chills/night sweats>1-2 weeks duration

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THERAPIST NOTES:

VENTURE PHYSICAL THERAPY / WEST COBB

Payment Policy

Venture Physical Therapy (VPT) -West Cobb's Customer Accounts Specialist makes every effort to verify coverage with your insurance company. **However, it is important for you to refer to your insurance policy to verify details, including limitations, regarding your coverage for outpatient physical therapy.** We cannot accept the responsibility of negotiating claims with insurance companies or other persons. If you prefer to send claims to your insurance company yourself, payments are due to Venture Physical Therapy / West Cobb at the time you receive services.

The patient (or parent, if the patient is a minor) is responsible for payment of charges incurred at VPT West Cobb. If payment is not received from the insurance company, workers compensation administration or other source within a reasonable period of time, the patient (or parent, if the patient is a minor) will be billed.

If you have more than one insurance policy, we can only bill one insurance company at a time. After your primary carrier responds to your claim, we will bill your secondary for the remainder. If your injury resulted from an automobile accident, your auto insurance carrier will be billed first. Patients are responsible for paying their co-pays, co-insurance and deductibles according to the terms of their insurance policy/policies.

If collection and/or legal services are required to obtain payment, patient (or parent, if patient is a minor) is responsible for all costs reasonably incurred including attorney fees, court costs, collection fees and interest at a rate of 1 ½% per month.

VPT West Cobb reserves the right to charge $20 for no show appointments or any cancellations not made 24 hours in advance of appointment time.

VPT - West Cobb's Customer Accounts Specialist invites early discussion of financial problems or questions regarding payment from insurance carriers. IF YOU HAVE QUESTIONS ABOUT YOUR ACCOUNT, PLEASE CALL OUR CUSTOMER ACCOUNTS SPECIALIST, 770 425-2268.

I have read the above payment policy, and I understand my responsibilities. I further understand that insurance may be filed by Venture Physical Therapy / West Cobb as a courtesy and that this does not constitute a contract between therapist and insurance company for payment for services.

_____ _____

Patient or authorized person (signature) Date

I authorize the release of any medical information necessary to process the claim for services rendered to me. I further authorize payment of medical benefits directly to the therapist. Photo static copies of this authorization shall be considered as effective and valid as the original.

_____ _____

Patient or authorized person (signature) Date

VPT – West Cobb maintains the privacy of patient health information. I am aware that VPT's Notice of Privacy Policies is posted in the waiting room and that I may ask the secretary for a copy of the Notice to take home with me.

_____ _____

Patient or authorized person (signature) Date