VIRGINIAN
PHYSICAL THERAPY
& STAFFING

Authorization and Consent to Treat Minor

Date:___/____/_____ .

Patient Name:_____.

Patient Birthdate:_____/_____/_____.

The undersigned does herby authorize Virginian Physical Therapy and Staffing LLC consent to exam and treat the above mentioned minor by employees of Virginian Physical Therapy and Staffing LLC without a parent or guardian present.

Father or Guardian:_____

(Signature)

Mother or Guardian:_____

(Signature)

Witness:_____

(Signature)

Important Medical Information (Allergies, Medications, etc):

_____

_____

_____

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Name: _____ Date: _____ Primary Care Physician: _____

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

- ❑ Changes in bowel or bladder function
- ❑ Weight loss/gain
- ❑ Fever/chills/sweats
- ❑ Nausea/vomiting
- ❑ Shortness of Breath
- ❑ Pain at night
- ❑ Dizziness/lightheadedness
- ❑ Headaches
- ❑ Weakness/fatigue
- ❑ Difficulty maintaining balance while walking
- ❑ Changes in appetite

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

- ❑ Cancer(type)_____.
- ❑ Rheumatoid arthritis
- ❑ Diabetes
- ❑ Heart disease
- ❑ Stroke
- ❑ Multiple sclerosis
- ❑ High blood pressure
- ❑ Depression
- ❑ Kidney/ liver problems
- ❑ Asthma
- ❑ Anemia
- ❑ Stomach ulcers
- ❑ Pacemaker inserted
- ❑ Lungs problems
- ❑ Parkinson's disease
- ❑ Epilepsy
- ❑ Osteoporosis
- ❑ Thyroid problems (Hyper / Hypo) (Circle one)
- ❑ Chemical dependency
- ❑ Other

During the past month have you been feeling down, depressed or hapless? **YES** **NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES** **NO**

Do you Smoke? YES NO

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

Please list current medications:_____

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES** **NO**

ALLERGIES:_____ARE YOU **LATEX SENSITIVE**? **YES** **NO**

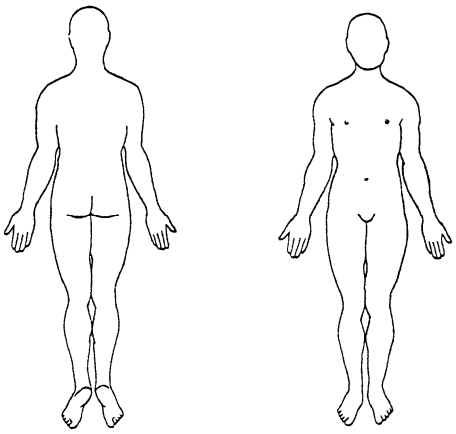
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____2. _____3. _____

Please mark the location of your pain and type of pain on the chart:

Key: **X** sharp stabbing pain. **O**: Dull achy pain **….** Numb/Tingling **////** Throbbing **==**Burning

BODY CHART



1. Pain at lowest: rate your lowest pain level in past 24 hrs.

_____

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

2. Pain Currently: Rate your level of pain at this time.

_____

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

3. Pain at Worst: Rate your highest pain level in past 24 hrs.

_____

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

_____

List activity (important one) you are unable or have difficulty performing as a result of our pain or symptoms (ex. Stairs, walking, bending, reaching overhead)

_____ .

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

What is your goal of therapy at this time?

Patient signature:_____**Date:**_____

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Patient Notification Policy

Name: _____ Account #:_____

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and our Notice of Privacy Practices, Virginian Physical Therapy and Staffing LLC, will not disclose your protected health information ("PHI") without your explicit authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, Virginian Physical Therapy and Staffing LLC, will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, Virginian Physical Therapy and Staffing LLC will only disclose your appointment information, such as reminders or cancellations, on an answering machine, voice mail, text message or e-mail, unless you inform us otherwise. This notice refers to Virginian Physical Therapy and Staffing LLC, as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself."

I, the undersigned, hereby authorize Virginian Physical Therapy and Staffing LLC, to disclose my appointment information by the following methods of communication and I assume all responsibility for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable:

Answering Machine ( )_____
Voice Mail ( ) _____
Text Message ( ) _____
E-Mail _____

Patient/Guardian Signature: _____ Date: _____

If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization. I further agree to be responsible for notifying Virginian Physical Therapy and Staffing LLC, if any of the foregoing change.

I, the undersigned, hereby authorize Virginian Physical Therapy and Staffing LLC, to disclose my PHI to the person(s) named below.

Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#

Patient/Guardian Signature: _____ Date: _____

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PHYSICAL THERAPY ATTENDANCE POLICY

Virginian Physical Therapy and Staffing LLC, strives to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery.

While we are sensitive to the fact that an emergency may occur, cancellations, tardiness and absentees reduce our ability to accommodate the scheduling needs of our patients. As such, we request your full cooperation with the following company policy:

- If a patient is more than 30 minutes late for an appointment and fails to notify the clinic of the tardiness, treatment may be cancelled and a cancellation fee charged for missing the appointment.
- A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE** or a cancellation fee will be charged for that appointment.
- Failure to show up for a scheduled appointment without providing the clinic advanced notification of your absence will result in a fee being charged for that appointment. Furthermore, 2 consecutive absences without advanced notification may result in the cancellation of all your remaining scheduled appointments, as such failures may negatively impact your treatment plan.
- ALL PATIENTS that cancel a scheduled appointment less than 24 hours in advance, are late to an appointment or absent from a scheduled appointment will be charged a **$50.00 CANCELLATION FEE. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE COMPANY OR THIRD PARTY PAYOR.** Please note that a cancellation fee will not be charged if the missed appointment is rescheduled within a week of the tardiness, absence or late cancellation and you do not have another appointment scheduled.
- All cancellations and absences will be documented in your medical record and reported to your physician and insurance company or third party payor.
- Repeated failure to comply with this policy will result in your appointments being scheduled based on availability, which will require you to call for an appointment on the day you would like to receive therapy.

By signing below, I acknowledge that I have read the foregoing company policy and agree to its terms:

_____ _____

Patient Acknowledgement/Signature Date

Virginian Physical Therapy and staffing, LLC
20 Pidgeon Hill Dr. Suite 103
Sterling, VA 20165
Tel: (571) 313-0929
Fax: (571) 313-8270

PATIENT INFORMATION FORM

Please **PRINT** or ask to have this form filled out for you.

NAME: _____

HOME PHONE: (____) _____CELL PHONE: (____) _____ WORK PHONE: (____) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: M____ F____ BIRTH DATE: _____/_____/_____ SS#: _____-_____-_____

EMAIL: _____

OCCUPATION: _____

EMPLOYER: _____

ADDRESS: _____

PHONE: (_____) _____ EXT #:_____

SPOUSE'S NAME: _____ SS#: _____

SPOUSE'S DATE OF BIRTH: _____ WORK PHONE: (_____) _____

SPOUSE'S EMPLOYER: _____

PRIMARY INSURANCE COMPANY: _____

CLAIM'S ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP CODE

INSURED'S NAME: _____ INSURED'S ID#: _____

INSURED'S GROUP #: _____ RELATIONSHIP TO INSURED: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SS#:_____

SECONDARY INSURACE COMPANY: _____

CLAIM'S ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP CODE

INSURED'S NAME: _____ INSURED'S ID#: _____

INSURED'S GROUP #:_____ RELATIONSHIP TO INSURED: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SS#: _____

REFFERRED BY: _____

REASON FOR REFFERRAL: _____

Virginian Physical Therapy and staffing, LLC

Assignment of Benefits Authorization, Responsibility for Payment and
Acknowledgement of Receipt of Notice of Privacy Practices

I understand that I am financially responsible for the services provided to me by Virginian Physical Therapy and Staffing, LLC regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Virginian Physical Therapy and Staffing, LLC for any services provided to me by Virginian Physical Therapy and Staffing, LLC I authorize and direct any holder of medical information or documentation about me to release to the centers for Medicare and Medicaid Services and its carriers and agents, as well as to Virginian Physical Therapy and Staffing, LLC and its billing agents and any other payers or insurer any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Virginian Physical Therapy and Staffing, LLC now or in the future. I agree to immediately remit to Virginian Physical Therapy and Staffing, LLC any payments that I receive from any source for the services provided to me and I assign all rights to such payment to Virginian Physical Therapy and Staffing, LLC. The undersigned hereby guarantees payment to Virginian Physical Therapy and Staffing, LLC of all charges incurred, and if account is turned over for collection, he/she agrees to pay all cost of collection including collection fee equal to 33.3% of all sum due and payable. The undersigned here agrees to pay interest at a rate of 18% per annum (annual percentage rate) on all outstanding balances.

I, _____, also acknowledge that Virginian Physical Therapy and Staffing, LLC has notified me that the Notice of Privacy Practices is publicly displayed for my review in the office waiting room. For additional information and/or questions, I am aware that I may contact the privacy officer of Virginian Physical Therapy and Staffing, LLC.

_____ Date: _____
Patient Signature

_____ _____
Patient Representative's Signature Relationship to Patient