DYNAMICS Physical Therapy

504 Elden Street, Suite 2, Herndon, VA 20170 – Tel 703-793-4851 – Fax 703-793-4853
7210 Heritage Village Plaza, Gainesville, VA 20155 – Tel 703-754-0394 – Fax 703-754-0254
6856 Piedmont Center Plaza, Gainesville, VA 20155 – Tel 703-754-6955 – Fax 703-754-6956

## PATIENT INFORMATION

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

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

Name: _____ Social Security #: _____
*Last* *First* *Middle Initial*

DOB: _____ Age: _____ Gender: Male / Female Marital Status: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Physician: _____ How did you hear about us? _____

☐ Worker's Compensation ☐ Auto Accident ☐ Other Date of Injury/Accident: State:

## 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: _____ Employer:_____

Subscriber: Relationship: SS#: DOB:

Secondary Insurance: _____ Employer:_____

Subscriber: Relationship: SS#: DOB:

**Card/Policy Holder (if other than patient)**

Name: _____ M / F SS#: _____ DOB: _____

Address: _____ Marital Status: _____ Occupation: _____

_____ Employer: _____

Home Phone: _____Work Phone: _____ Employer Address: _____

## WORKERS COMPENSATION/AUTO INSURANCE

Insurance Carrier: _____ Contact/Phone #: _____

Claim #: _____ Address: _____

## VERIFICATION OF INSURANCE (For Office Use Only)

As a courtesy, we will verify your primary insurance carrier on your behalf. Your benefits have been verified and are as follows:

☐ $ _____co-payment due per visit

☐ _____% coverage after a $ _____ deductible up to _____

➢ **ATTENTION: SIGNATURE REQUIRED ON REVERSE**

DYNAMICS
Physical Therapy

## REFERRAL RESPONSIBILITY

It is not the responsibility of Dynamics Physical Therapy Group, Inc. or any of its employees to know the benefits and/or the requirements of any given health insurance provider. It remains the responsibility of the individual patient to know their benefits and/or requirements of their private health insurance provider. If a referral is required by the patient's private health insurance provider prior to receiving any physical therapy benefits at Dynamics Physical Therapy Group, Inc., it is the sole responsibility of the patient to obtain this referral from the required source. If a referral is required prior to receiving physical therapy services and one is not obtained and presented during the initial visit, it will be the patient's sole responsibility to pay for any physical therapy services rendered on that day. This applies to any subsequently required referrals as well.

## 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 Dynamics Physical Therapy Group, Inc. provide treatment and care as prescribed by my physician and/or as 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 the benefits to which I may be entitled.

## PATIENT AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize Dynamics Physical Therapy Group, Inc. to apply for benefits on my behalf for services rendered, and request payment from my insurance carrier be made directly to Dynamics Physical Therapy Group, Inc. 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 receive 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 beyond an 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 one-third (33 1/3%) of the principal amount in attorney fees.

**RETURNED CHECK FEE**: I understand that Dynamics Physical Therapy Group, Inc. has an established policy whereby $25.00 will be charged for each check returned by a bank for insufficient funds.

**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 Dynamics Physical Therapy Group, Inc. has a valid authorization form before each visit. These forms cannot be issued retroactively. Failure to obtain authorization may drastically reduce your benefits/coverage with your insurance carrier.

**CANCELLATION POLICY**: We require 24 hours notice prior to an appointment cancellation. There will be a charge of $30.00, per appointment, if this policy is not observed. Prior notification enables us to open our waiting lists to new and existing patients in case of an appointment cancellation. Thank you for respecting this policy.

---

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

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

Signature: _____ Date: _____

Printed Name: _____

**504 Elden Street, Suite 2, Herndon, VA 20170 – Tel 703-793-4851 – Fax 703-793-4853**
**7210 Heritage Village Plaza, Suite 101, Gainesville, VA 20155 – Tel 703-754-0394 – Fax 703-754-0254**
**6856 Piedmont Center Plaza, Gainesville, VA 20155 – Tel 703-754-6955 – Fax 703-754-6956**

# Consent for Release and Use of Confidential Information & Notice of Privacy Practices Acknowledgement

I, _____, hereby give my consent to Dynamics Physical Therapy
(Name of Patient, Guardian, or Authorized Agent)

Group Inc. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of:

_____.
(Print "SELF) or Name of Patient

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.

I understand that the practice has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the Privacy Officer. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the therapist's office.

I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed: _____Date: _____

If you are not the patient, please specify your relationship to the patient: _____

**FOR OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

| **Date:** | **Initials:** | **Reason:** |
|---|---|---|
| | | |

DYNAMICS Physical Therapy

**NAME**_____ **AGE** _____ **DATE**_____

**For any YES answers, please describe including date of occurrence/diagnosis below.**

**1. GENERAL:**

| | | |
|---|---|---|
| Diabetes? | No | Yes |
| Metal implants? | No | Yes |
| Recent unexplained weight loss? | No | Yes |
| Night pain? | No | Yes |
| Appetite loss? | No | Yes |
| Night sweats? | No | Yes |
| Current infection? | No | Yes |
| Hot/cold intolerance? | No | Yes |
| Fatigue? | No | Yes |
| Cancer? | No | Yes |
| Fibromyalgia? | No | Yes |
| HIV positive? | No | Yes |

**2. CARDIOPULMONARY:**

| | | |
|---|---|---|
| Heart disease? | No | Yes |
| Family history of diabetes or heart disease? | No | Yes |
| High blood pressure? | No | Yes |
| A respiratory illness? | No | Yes |
| Pacemaker? | No | Yes |

**3. ALLERGIES:**

| | | |
|---|---|---|
| Allergies to medication? | No | Yes |
| Other allergies? | No | Yes |

4. **EYES, EARS, NOSE, THROAT, ORAL:**

| | | |
|---|---|---|
| Temporomandibular joint pain (TMJ)? | No | Yes |
| Hearing loss? | No | Yes |
| Glaucoma? | No | Yes |
| Dizziness? | No | Yes |

**5. SKIN**:

| | | |
|---|---|---|
| Contagious rash? | No | Yes |
| Fungus? | No | Yes |

**6. BREASTS (For Women):**

| | | |
|---|---|---|
| Lumps? | No | Yes |
| Surgery (i.e. tumor removal, Implants, etc.)? | No | Yes |

**7. HEMATOLOGIC:**

| | | |
|---|---|---|
| A blood disease such as hemophilia, or other bleeding tendencies? | No | Yes |
| Anemia? | No | Yes |
| Leukemia? | No | Yes |

**8. VASCULAR:**

| | | |
|---|---|---|
| Poor circulation in hands or feet? | No | Yes |
| Thrombophlebitis? | No | Yes |
| Varicose veins? | No | Yes |
| Skin irritations? | No | Yes |
| Tendency to bruise? | No | Yes |
| Phlebitis? | No | Yes |

**9. RENAL/URINARY:**

| | | |
|---|---|---|
| Kidney Disease? | No | Yes |
| Incontinence? | No | Yes |

**10. PSYCHIATRIC:**

| | | |
|---|---|---|
| Anxiety/Depression? | No | Yes |
| Counseling? | No | Yes |

**11. CHEMICAL USE:**

| | | |
|---|---|---|
| Smoking? | No | Yes |
| Alcohol? | No | Yes |
| Non-prescription drug use? | No | Yes |

**12. NEUROLOGICAL:**

| | | |
|---|---|---|
| Headaches? | No | Yes |
| Seizures? | No | Yes |
| Numbness? | No | Yes |
| Weakness? | No | Yes |
| Slurred speech? | No | Yes |

**13. GASTROINTESTINAL:**

| | | |
|---|---|---|
| Enlarged liver or spleen? | No | Yes |
| Nausea or vomiting? | No | Yes |
| Ulcer? | No | Yes |
| Crohn's Disease or Irritable Bowel? | No | Yes |
| Hernia? | No | Yes |

**14. GENITO-REPRODUCTIVE:**

| | | |
|---|---|---|
| Pregnant now? Yes No Ever? | No | Yes |
| Hormonal imbalance or replacement therapy? | No | Yes |
| Infections? | No | Yes |
| Surgeries (i.e. prostate, hysterectomy)? | No | Yes |

**15. MUSCULOSKELETAL:**

| | | |
|---|---|---|
| Arthritis? | No | Yes |
| Osteoporosis? | No | Yes |
| Previous fractures? | No | Yes |
| Previous sprains/strains? | No | Yes |
| Previous back or neck injury? | No | Yes |
| Other? | No | Yes |

**16. EXERCISE/ACTIVITY:**

| | | |
|---|---|---|
| Do you exercise regularly (at least 3 times per week)? | No | Yes |

Doing what? _____

How much time each day are you willing and able to do exercises given to you by your physical therapist?

_____

**17. MEDICATIONS:**

1. _____
2. _____
3. _____
4. _____
5. _____

Please use the reverse side if more space is needed. I certify this medical history is accurate and complete.

Date _____

Signature _____
Patient, Parent or Legal Guardian

PT Reviewed _____

DYNAMICS
Physical Therapy

**www.dynamicsphysicaltherapy.com**

**NAME**_____ **AGE** _____ **DATE**_____

**BRIEF DESCRIPTION OF CURRENT PROBLEM**: _____

_____

**HOW LONG HAVE YOU HAD PROBLEM**: _____ Days _____ Weeks _____ Months _____ Years

**HAVE YOU HAD SURGERY?** _____ Date _____

_____

**1)** **Using the number rating system below, describe your:**

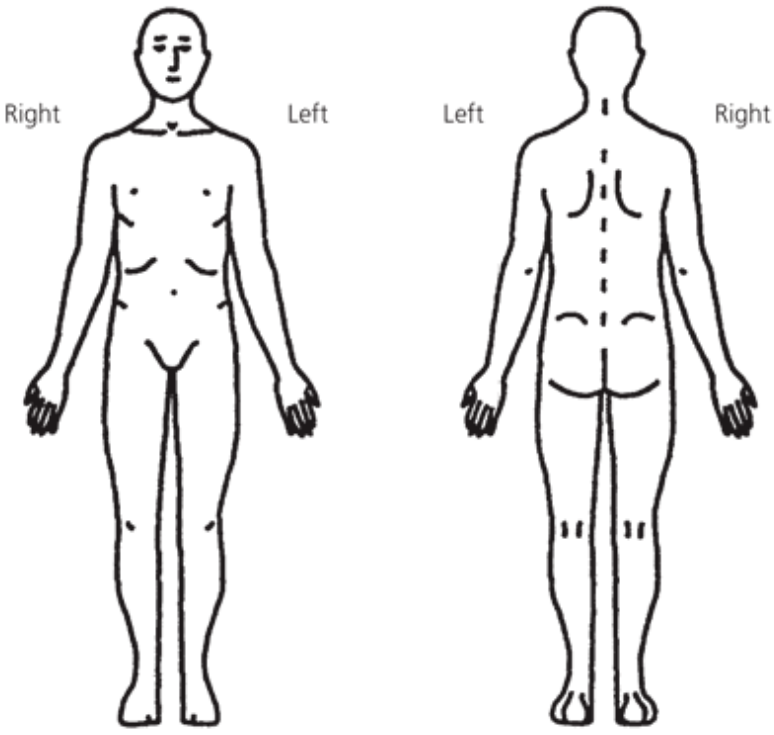
| | | |
|---|---|---|
| | **Pain level *NOW*:** | (0-10) |
| In the past ***30 days***: | Pain level at **BEST**: | (0-10) |
| In the past ***30 days***: | Pain level at **WORST**: | (0-10) |

Pain Scale:


| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| None | | Mild | | | Moderate | | | Severe | | |

_____

**2)** **Use the symbols listed <u>below</u> to describe the location and type of pain or unusual feelings you are having by drawing them on the pictures.**




| | |
|---|---|
| **OOOO** | **Pins and Needles** |
| **XXXX** | **Numbness** |
| **//////////** | **Pain** |
| **= = = =** | **Other** |