



NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change in accordance with Federal regulations. A current copy is available in the waiting room and may be obtained upon request.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed. We are not required to agree to this restriction, but if we do, we are bound by our agreement. Any request to restrict our use of your information must be done in writing to our practice Privacy Officer at 8254 Atlee Road • Mechanicsville, VA 23116.

PT Works intends to use and disclose the minimum necessary PHI about you for treatment, payment, or health care operations. Other uses and disclosures not described as permitted in our Notice of Privacy Practices will require a current signed and dated authorization from you or your legal appointed representative.

I, \_\_\_\_\_ have been provided a copy of the  
(Please print patient name)

Notice of Privacy Practices for PT Works.

I understand that I may ask questions to PT Works staff if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor or is unable to sign:

Authorized Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_



**CONSENT FOR CARE AND TREATMENT**

I, the undersigned, do hereby agree and give my consent for PT Works to furnish medical care and treatment considered necessary and proper in diagnosing or treating this patient's physical condition.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

**BENEFIT ASSIGNMENT/RELEASE OF INFORMATION**

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors, to PT Works. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment. Further, PT Works reserves the right to make changes to our privacy policy at anytime in order to remain in compliance with State and Federal regulations.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

**FINANCIAL POLICY STATEMENT**

We bill your insurance carrier solely as a courtesy to you. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to PT Works.

Should the patient fail to obtain the initial authorization PRIOR to treatment, the patient will be held responsible for payment.

The above does not apply to those patients who are considered for Workman's Compensation. However, be advised that if you claim W/C benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read by and explained to me.  
I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

PT Works representative/witness: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_



Appointment Date \_\_\_ / \_\_\_ / \_\_\_ Appointment time: \_\_\_\_\_ Account #: \_\_\_\_\_

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birthdate: \_\_\_ / \_\_\_ / \_\_\_ Email address \_\_\_\_\_  
Employer: \_\_\_\_\_ Sex: M F  
Employer Address: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
Employer City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Contact Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Reason for visit: \_\_\_\_\_ Accident Type: None W/C Auto Other  
\_\_\_\_\_ Accident/Injury onset date: \_\_\_ / \_\_\_ / \_\_\_

### PRIMARY INSURED INFORMATION

Name of Primary Insured: \_\_\_\_\_ Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Relation to Patient: Self Spouse Parent Other Birthdate: \_\_\_ / \_\_\_ / \_\_\_  
Employer: \_\_\_\_\_ Sex: M F

### RESPONSIBLE PARTY INFORMATION *(If different from above)*

Name of Responsible Party: \_\_\_\_\_ Relation to Patient: Self Spouse Parent Other  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### FOR OFFICE USE ONLY

Referring Physician: \_\_\_\_\_ Dr. Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Physician Address: \_\_\_\_\_ NPI #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ UPIN #: \_\_\_\_\_  
Therapist: \_\_\_\_\_ Prescription Date: \_\_\_ / \_\_\_ / \_\_\_  
Comments: \_\_\_\_\_ #Visits Ordered: \_\_\_\_\_  
\_\_\_\_\_ Diagnosis Code: \_\_\_\_\_



## PATIENT MEDICAL HISTORY AND SOCIAL SERVICE QUESTIONNAIRE

Name: \_\_\_\_\_  
Referring physician: \_\_\_\_\_  
Family physician: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
What aggravates your symptoms? \_\_\_\_\_  
\_\_\_\_\_

Last date worked due to this injury: \_\_\_ / \_\_\_ / \_\_\_  
Date returned to work after this injury: \_\_\_ / \_\_\_ / \_\_\_ Is an at-  
torney involved in this case?  Yes  No  
Have you had surgery for this injury?  Yes  No  
Type of surgery: \_\_\_\_\_  
Date of surgery: \_\_\_ / \_\_\_ / \_\_\_ Surgeon: \_\_\_\_\_

Are you currently taking any prescription or non-prescription medications?  Yes  No  
Anti-inflammatories  Yes  No Pain medications  Yes  No  
Muscle relaxers  Yes  No List other medications \_\_\_\_\_

Have you had any of the following medical or rehabilitative services for this injury/episode?

Chiropractor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CT Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EMG/NCV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	General Practitioner	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Massage Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	MRI	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Myelogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurologist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Occupational Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthopedist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No When? ___ / ___ / ___	Podiatrist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emergency Room Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	X-Rays	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you now have, or have you ever had any of the following?

Asthma, Bronchitis or Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Severe or frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath/chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision or hearing difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coronary heart disease or angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness or tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a pacemaker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness or fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart attack/Heart surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight loss/Energy loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood clot/Emboli	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid trouble/Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any pins or metal implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel or bladder problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neck injury/surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infectious diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shoulder injury/surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer/Chemotherapy/Radiation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Elbow/hand injury/surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis/swollen joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Back injury/surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Knee injury/surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleeping problems/difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Leg/ankle/foot injury/surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional/psychological problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Please rate your pain (0 no pain – 10 extreme pain) \_\_\_\_\_ Currently \_\_\_\_\_ At rest \_\_\_\_\_ With Activity  
What are your expectations/goals while in this program? \_\_\_\_\_

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_



## CANCELLATION POLICY

Patients who need to cancel physical therapy appointments must call to do so 24 hours prior to their scheduled appointment time. Our office staff will make every effort to reschedule that appointment at another time the same day of the original appointment. Failure to give 24 hours notice of cancellation of three (3) consecutive appointments, or cancellation of two (2) or more appointments per week will result in a charge of \$25 for each missed appointment. If your therapy needs to be put on hold, please speak with your therapist. Patients who "No Show" for more than one appointment will be charged a \$50 "No Show" fee for each missed appointment. (A "No Show" is defined as a missed appointment that the patient has not cancelled prior to their appointment time.) Remember, in order for you to make progress, you need to attend therapy with the frequency that your physician and your therapist have prescribed. Additionally, if you are receiving therapy under Workman's Compensation, recurrent cancellation or any "No Show" may result in the loss of all Workman's Compensation benefits.

## CO-PAYS and DEDUCTIBLES

During your initial visit, we will contact your insurance company to verify coverage and to determine your co-pay and deductible amounts. If your policy stipulates that you are responsible for a deductible and/or co-insurance payment, PT Works is contractually obligated to collect those payments, and we ask that those payments be made at the time of service.

## SUPPLY POLICY

With the exception of Workman's Compensation and Medicare/Medicaid, PT Works does not bill insurance companies for supplies. If your physician and your therapist deem that it is medically necessary for you to be issued any Durable Medical Equipment (DME) or other supplies, you will be required to pay for the equipment or supplies at the time that it is issued. You will be provided with a receipt and, if applicable, a copy of your physician's prescription for the equipment or supplies which you may then submit to your insurance company directly for reimbursement.

PT Works issues a receipt to all patients making a payment at our facility.

I, the undersigned, have read and understand the above information.

Name: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_