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www.novaphysicaltherapy.com

PATIENT INFORMATION FORM

(Please complete the following information, sign, date and return this form to the receptionist)

I. PATIENT INFORMATION

a. First Name Last Name Middle Name

b. Gender: Select

c. Date of Birth: Age: Height: Ft inches Weight: lbs

d. Current Address:

City: State Zip Code

e. Cell No: Home/Office No: Other No

f. Email Address:

g. SSN #: Driving License No Issuing State

h. Emergency Contact Information:

1. Name/ Relation:
2. Contact No:

II. PRIMARY CARE PROVIDER

a. Name of Primary Care Provider:

b. Facility Name/Location:

c. Contact No: Fax No:

III. REFERRAL INFORMATION:

a. Who referred you to us:

b. Phone No: Fax No:

IV. EMPLOYMENT INFORMATION

a. Employment Status: Select

b. Name of the Employer:

c. Designation:

PRINT NAME: **SIGN:** **DATE:**

V. INSURANCE INFORMATION

	PRIMARY	SECONDARY
Name of the Insurance		
Name of Insured		
Date of Birth		
Relation to Patient		
Id #		
Group #		

VI. REHAB INFORMATION

1. Chief complaint/Ailment/Injury:
2. Date of Injury: Date of Surgery (*if applicable)*
3. Briefly Describe how you were injured:
4. Have you received therapy for this condition? Yes ○ No ○
5. If yes when How many visits?
6. Has your conditions been: Getting Better ○ Getting Worse ○ Same ○
7. Are your Symptoms: Constant ○ Intermittent ○
8. Select the number that best corresponds to your pain: At Best select At Worst: Select
9. What makes your condition better (Select/Mark all that applies)

   Bending ☐ Movement ☐ Rest ☐ Better In Am ☐ Changing Position ☐

   Sitting ☐ Standing ☐ Heat ☐ Better as day progresses ☐ Rising ☐

   Walking ☐ Ice ☐ Better in PM ☐ Lying ☐ Medication ☐ N/A Cast just removed ☐
10. What makes your condition worse (Select/Mark all that applies)

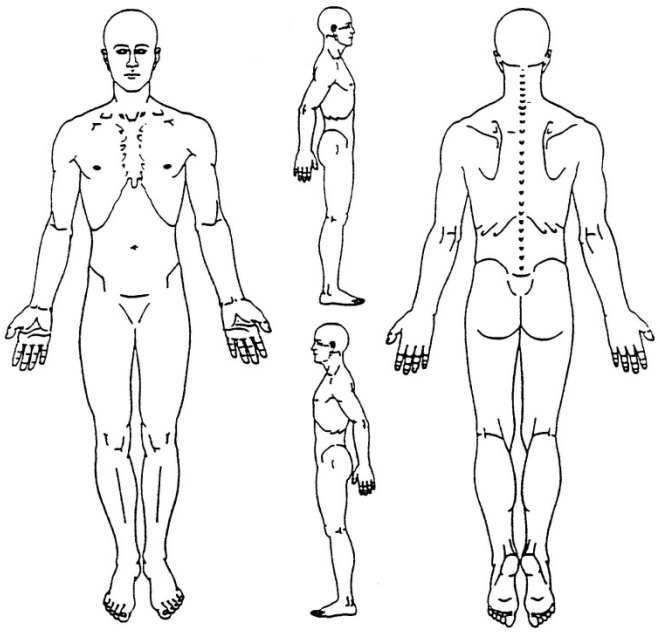
    Bending ☐ Movement ☐ Rest ☐ Better In Am ☐ Changing Position ☐

    Sitting ☐ Standing ☐ Heat ☐ Better as day progresses ☐ Rising ☐

    Walking ☐ Ice ☐ Better in PM ☐ Lying ☐ Medication ☐ N/A Cast just removed ☐
11. Previous Medical Intervention (Select/Mark all that applies)

    X-ray ☐ MRI ☐ CATSCAN ☐ Injections ☐ Other
12. What goals do you intend to achieve by the end of the therapy? :

13. Draw in areas of pain on body diagrams using appropriate symbols. If you are completing this form on your computer, print form after completion and mark the diagram with a pen.



Severe Pain: **********
Moderate Pain: 0000000000000
Dull Ache: ∩∩∩∩∩∩∩∩∩∩∩
Radiating Pain: ↓↑↓↑↓↑↓↑↓↑↓↑↓↑
Numbness/Tingling: XXXXXXX

14. **Medical Information** (Select/Mark all that applies) *(This information is confidential and will remain part of your chart to help the therapist better treat you)*

Difficulty Swallowing ☐	Motion Sickness ☐	Stroke ☐	Arthritis ☐
Fever/Chills/Sweats ☐	Osteoporosis ☐	Anemia ☐	Diabetes ☐
High Blood Pressure ☐	Blood Clots ☐	Heart Trouble ☐	Pacemaker ☐
Unexplained Weight Loss ☐	Shortness of Breath ☐	Hepatitis ☐	HIV ☐
Epilepsy/Seizure ☐	Depression ☐	Anxiety ☐	Pregnancy ☐
History of Drug Abuse ☐	Myofascial Pain ☐	Fybromyalgia ☐	Cancer ☐

15. Have you had any previous surgeries: No
16. If yes please List them:
17. Do you Smoke: Select If Yes please indicate how many cigarettes /week
18. Do you drink: Select If Yes please indicate how many drinks/week
19. Current Medications:
20. Allergies (if any):

PRINT NAME: **SIGN:** **DATE:**

VII. ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices from NOVA REHABILITATION Inc., (**NOVA Rehab**)

Sign _____ **Date** _____

In lieu of patient signature, I, _____, a staff member of NOVA Rehab state that _____ has been given our current Notice of Privacy Practices.

Sign _____ Date _____

Discussion of Treatment/Medical Information

a. If you are accompanied to your physical therapy session(s) is it acceptable to discuss your medical information with the individual(s) present? **Yes** ◯ **No** ◯

b. Is there any individual, besides your doctor and involved health care practitioner(s), with whom you would allow NOVA REHAB to discuss/release your treatment plan/medical information? Please check as appropriate and print the individual's name: Select

RELATION	FULL LEGAL NAME
Spouse/Significant other Y/N	
Son/Daughter Y/N	
Friend Y/N	
Others Y/N	

PRINT NAME: _____ **SIGN:** _____ **DATE:** _____

VIII. FINANCIAL POLICY STATEMENT

We would like to thank you for choosing NOVA REHAB to provide for your healthcare needs. The policies listed below have been approved by the management with the goal of providing the finest care and service to our patients at the least cost.

Care delivered by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or gender.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding your financial responsibility and our payment policy.

a. RESPONSIBILITY FOR THE BILL: It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the clinic in effect at the present time.

b. Co-Payments: Co-payments must be paid upon the patient's arrival. We accept cash, check and most major credit/debit cards.

c. POINT OF SERVICE COLLECTIONS: Payment for service is due at the time to service(s) is rendered and non-emergency services may be declined until the necessary payment arrangements have been accomplished.

Payment will be accepted in cash, checks, and most major credit/debit cards. We will be happy to file verified insurance on your behalf. For your convenience if your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of **$50.00**.

Patients unable to comply with the Point-of-Service payment policy will be referred to the administrative office for necessary arrangements.

d. PATIENT SCHEDULING: Every effort will be made to schedule the patient at the patient's convenience. Patients will be advised of the clinics payment policy at the time appointments are made along with the best estimate of the cost of the office visit.

e. **APPOINTMENT/CANCELLATION POLICY:** I understand that physical therapy has been prescribed for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I understand that if I am late for my appointment, I may be given the opportunity to reschedule my appointment or to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three cumulative appointments, NOVA Rehab may discharge me from care for being non-compliant.

   I understand and agree that NOVA Rehab requires 24 hours notice of cancellation prior to the scheduled appointment time. Should I fail to give 24 hours prior notice of cancellation or fail to show up for an appointment, I will be charged a **$30** cancellation/no show fee (which is not covered by insurance).

f. **ACCEPTANCE OF INSURANCE:** The clinic will accept "Assignment of Benefits" on verified insurance policies and submit a bill to the carrier on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Claims filed will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all the claims not paid within the allowed period of time.

g. **VERIFICATION OF INSURANCE:** Because of the wide range of insurance plans in effect, the clinic will verify insurance coverage, deductibles and other limits, prior to acceptance for payment of services.

h. **PRE-CERTIFICATION:** The clinic will make every effort to pre-certify all services, provided the clinic is supplied with the necessary information

i. **REJECTED CLAIMS:** Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf.

j. **RELEASE OF INFORMATION:** By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

k. **PATIENT RESPONSIBILITY:** Balances after insurance are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the clinic. Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers the service or not. The clinic cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

l. **OUTSTANDING BILLS:** The clinic reserves the right to request deposits and payments for outstanding balances. Deposits will be based on the outstanding balance plus the patient's share of the bill for the new services to be performed.

m. **HEALTHCARE LIENS:** The clinic reserves the right to file healthcare liens against the patient and other responsible parties as is deemed appropriate to protect the clinic interest.

n. **BAD DEBTS/LEGAL ACTION:** If the account is not paid in full or satisfactory arrangements made within the allowable time frame, the clinic reserves the right to refer the account to an attorney and/or a collection agency for collection of the balance. I agree to assume responsibility for all charges incurred should collections of this balance become necessary including court costs and attorney's fee.

   The administrative and management welcomes the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality healthcare.

o. **JURISDICTION**: In the event that NOVA must file a law suit to collect a debt, I agree the jurisdiction shall be in the courts of Loudoun County, VA.

I have read the Financial Policy/Policy Statement and understand regarding above.

PRINT NAME: _____ **SIGN:** _____ **DATE:** _____