VILLAGE PHYSICAL THERAPY

Michele Childs, PT

PATIENT NAME:_____ SOCIAL SECURITY NUMBER:_____

ADDRESS: _____ CITY:_____ ZIP:_____

HOME PHONE:( )_____ CELL PHONE:( )_____ WK PHONE:( )_____

BIRTHDATE: _____ AGE:_____ SEX: M_____ F_____ MARITAL STATUS:_____

EMPLOYER: _____ ADDRESS: _____

E-MAIL ADDRESS: _____

SPOUSE (OR PARENT) NAME: _____ SOCIAL SEC. #:_____

SPOUSE/PARENT ADDRESS:_____ CITY:_____ ZIP:_____

EMERGENCY CONTACT NAME: _____PHONE: ( ) _____

We have permission to contact you at: ___home ___cell ___work ___email
We have permission to leave a message at ___home ___cell ___work ___email

Our **NOTICE OF PRIVACY PRACTICES** requires that we will keep your records safe.

☐ Check if you **DO NOT** wish to receive a copy of the NOTICE OF PRIVACY PRACTICES

Or ☐ Check if you WISH to receive a copy of the NOTICE OF PRIVACY PRACTICES

Patient Name:_____

My Signature:_____ Date:_____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Relationship to Patient:_____ Printed Name:_____

Source of authority if not a parent: _____

FOR OFFICE USE ONLY

We attempted to obtain acknowledgment of receipt, but could not because:

( ) Individual refused to sign ( ) Communication/language barrier ( ) Emergency situation ( ) Other:

Village Physical Therapy locations:

5825 Delmonico Dr, Suite 300 **Colorado Springs**, CO 80919 **Phone: 719.577.4104**
1721 Hwy 50 W, Suite 210 **Pueblo**, CO 81008 **Fax: 719.575.0872**
801 S Perry Street, Suite 105 **Castle Rock**, CO 80104

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MEDICAL HISTORY RECORD

Name: _____ **Date**:_____

Primary Care Physician: _____ **Phone**_____

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

bowel or bladder function	weight loss	fever/chills/sweats
nausua/vomiting	shortness of breath	pain at night
dizziness/lightheadedness/fainting	headaches	weakness/fatigue
changes in appetite	difficulty swallowing	stomach problems
skin rash	tightness of chest pain	pain/swollen joints
difficulty maintaining balance		

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

cancer(type)_____	arthritis/gout	diabetes
heart disease/heart problems	multiple sclerosis	stroke
pacemaker	kidney/bladder problems	asthma
trumatic brain injury/head injury	thyroid problems	epilepsy
depression/mental trouble	chemical dependency	anemia
osteoperisis	growths/tumors	blood clots
Parkinsens disease	stomach ulcers	seizures
high blood pressure	back problems	ear problems
lung disease/pnuemonia	Other_____	

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

Do you smoke? **YES NO** _____ pack/day

Current Medications	Medication	Dosage/day
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

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

ALLERGIES: _____ **Are you latex sensitive? YES NO**

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

	Date	
_____		_____
_____		_____
_____		_____
_____		_____

X_____ _____

Patient Signature **Date**

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Patient Agreement

Dear Patient,

Thank your for choosing Village Physical Therapy for your healthcare needs. Our providers and staff are dedicated to providing you the best care and customer service possible. Please take a few moments to read and sign the following patient agreement.

PATIENT AGREEMENT:

_____ (your name, herein called "patient") has entered into an agreement with Village Physical Therapy (herein called "VPT")

- I promise to conduct myself in an orderly manner while at VPT (no swearing, angry outbursts, rudeness, etc. to VPT staff or other patients) or I may be discharged from the practice
- I promise to call VPT at least 24 hours prior to my appointment to cancel or reschedule, so another patient can be treated in my time slot
- I understand if I "No Show" for an appointment, I may be charged a *$40 no call/no show fee*. I understand *this WILL BE PAID BY ME* personally and will not be billed to my insurance company. If two or more appointments are missed without notice, I may be discharged from the practice.
- I hereby consent to such treatment and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of VPT.
- I hereby understand that VPT is not responsible for any valuables and personal property brought to the facility.
- I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment prognosis, recommendations, benefits payable, as well as other data pertinent to my treatment by VPT to the physician who referred me for therapy as well as any organization responsible for payment of my account.
- I hereby authorize that the payment of authorized benefits be made directly to VPT for any services that are reimbursable by Medicare, Insurance or any third party.

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- I understand that I, the patient, am responsible for full payment of any and all services rendered by VPT to me and my family members, including all services and fees not covered by insurance. VPT bills my private insurance as a courtesy and I, as the subscriber, am responsible for understanding the terms of my policy. In the event of non-payment, I agree to pay all reasonable attorney fees and court costs if VPT refers my account to a third party collection agency.
- I understand that I am a participant in my own healthcare, and I am responsible for following my providers' healthcare plan for my own benefit.
- I understand that as long as I participate and uphold my end of this agreement, I am always welcome at VPT.

Date _____ 20_____

_____

Patient Name (print)

_____

Patient/Guardian Signature

ANY CHANGES OR ADDITIONS TO THIS AGREEMENT ARE NOT PERMITTED

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