



RVA PHYSICAL THERAPY WOMEN'S AND MEN'S PELVIC HEALTH

2620 A Gaskins Rd, Henrico, VA 23238, USA

Contact: (804) 282-3500 | (804) 396-6753

Fax : 888-815-8184 | www.rvaphysicaltherapy.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: Male Female
- 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 #: _____
- 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:
- Source of referral: Friend Primary care Magazine Others

IV. EMPLOYMENT INFORMATION

- a. Employment Status: _____
- b. Name of the Employer: _____
- c. Designation: _____

V. INSURANCE INFORMATION

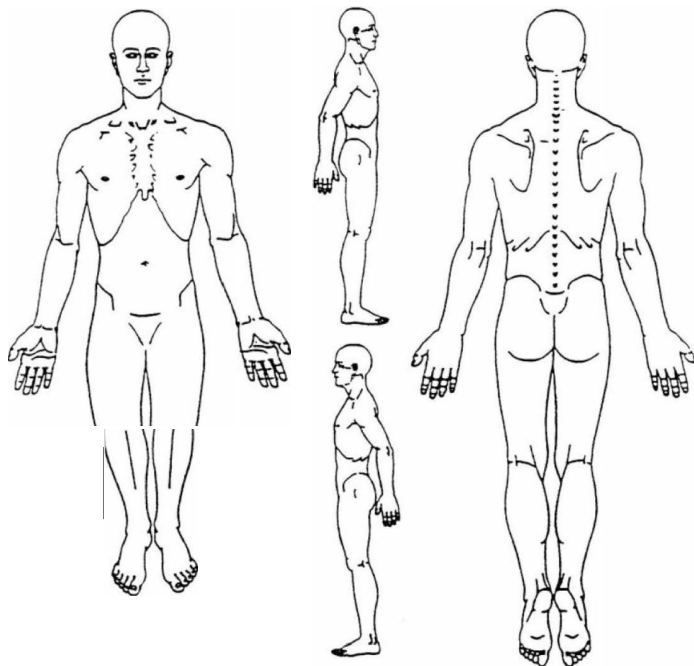
	PRIMARY	SECONDARY
Name of the Insurance		
Name of Insured		
Relation to Patient		
ID #		

Group #

VI. REHAB INFORMATION

- Chief complaint/Ailment/Injury: _____
- Date of Injury: _____ Date of Surgery (*if applicable*): _____
- Briefly Describe how you were injured: _____

- Have you received therapy for this condition? Yes No
- If yes when _____ How many visits?
- Select the number that best corresponds to your pain: At Best _____ At Worst: _____
- Previous Medical Intervention (Select/Mark all that applies)
X-ray MRI CATSCAN Injections Other _____
- 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:
Dull Ache:
Radiating Pain:
Numbness/Tingling:

9. **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

10. Have you had any previous surgeries: Yes No

11. If yes please List them: _____

12. Do you Smoke: Yes No If Yes please indicate how many cigarettes /week

13. Do you drink: Yes No If Yes please indicate how many drinks/week

14. Physical Therapy treatment includes Dry Needling treatment. If you do not opt for it, please check this box.

15. Current Medications:

16. Allergies (if any):

17. Birth History:

Number of Pregnancies: _____

Number of Deliveries: _____

Date of Deliveries	Vaginal or Cesarean birth	Second Stage of Labor duration (how long you pushed)	Infant Weight	Tearing or episiotomy

18. Gynecological:

Date of Last Menses: _____

Menopausal State: _____

Currently Sexually Active Yes No

Do you experience pain during intercourse? Yes No

Please list any gynecological conditions
(Fibroids/UTI/STI/Endometriosis/PCOS/etc): _____**19. Incontinence:**

Do you experience leakage with coughing, sneezing, laughing, jumping, or other high impact activity? Yes No

Explain: _____

Do you ever experience fecal leakage or do you feel like you cannot hold in gas? Yes No

Explain: _____

How long after the urge to urinate can you delay going to the bathroom? _____

20. Constipation:

How frequently do you have a bowel movement? _____

Do you have to strain to have a bowel movement? Yes No

Do you have hemorrhoids? Yes No

or pain with bowel movement ? Yes No

Explain: _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices from Women's Health Physical Therapy

INITIAL _____ **Date** _____

In lieu of patient signature, I, _____, a staff member of Women's Health Physical Therapy state that _____ has been given our current Notice of Privacy Practices.

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 Women's Health Physical Therapy to discuss/release your treatment plan/medical information? Please check as appropriate and print the individual's name:

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



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DRY NEEDLING THERAPY CONSENT FORM

Dear Sir/Madam,

Thank you for choosing WOMEN'S HEALTH PHYSICAL THERAPY. **Dry Needling Therapy** is a valuable treatment technique in managing chronic pain, acute pain, muscle stiffness and spasm, edema/ swelling, and painful muscle trigger points. Like any treatment procedure, there is risk for complications, and while these are uncommon they can occur and must be appropriately outlined prior to consenting to its use.

Dry Needling uses a thin, flexible, sterile needle to promote muscle relaxation, while increasing the ability of tissue to heal, and often results in pain relief. Dry Needling technique uses the same type of needles used in Acupuncture. However, Dry Needling treatment perspective is based solely on modern physiology, neurology and bio mechanics, rather than the ancient Traditional Chinese/Asian Theory of the energy, "Chi". Dry Needling is termed "dry" because at no time will a fluid or medication, be injected into your body. It therefore can be considered a natural therapy to help manage pain and injury.

Dry Needling may cause minor to moderate increases in muscle soreness and ache for up to two days. However, improvements in a patient's overall pain state can be expected to occur within the first 24 hours after treatment. If a needle touches a nerve, vein or artery and produces pain, bruising, numbness and/or tingling, it can be expected to resolve in a few days.

All needling procedures have a risk for infection. However, Dry Needling Therapy always utilizes new, sterile, disposable needles and thorough hand-washing procedures. If you currently have an; infection, cancer, hepatitis, HIV/AIDS, a pacemaker, are taking blood thinners and/or immunosuppressant medications (decreasing the strength of the immune system), then please inform your health care provider prior to beginning treatment.

I have read or have had this form read to me; and I understand the risks involved with Dry Needling Therapy. I have had the opportunity to ask questions and express any concerns, of which have been answered to my satisfaction.

I consent to Dry Needling Therapy treatment by my health care provider.

PRINT NAME: _____

DATE: _____

Signature

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FINANCIAL POLICY STATEMENT

We would like to thank you for choosing Women's Health Physical Therapy 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) **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, Women's Health Physical Therapy Rehab may discharge me from care for being non-compliant.

I understand and agree that Women's Health Physical Therapy 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 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 Women's Health Physical Therapy must file a law suit to collect a debt, I agree the jurisdiction shall be in the courts of Henrico County, VA.
- I have read the Financial Policy/Policy Statement and understand regarding above.

PRINT NAME: _____

DATE: _____

Signature