

Name: First _____ Middle _____ Last _____

If a minor: Parent(s) or Guardian(s) Name _____

Address _____ City _____ ST _____ ZIP _____

SS# _____ - _____ - _____ PH # _____ Cell / Pager # _____

Date of Birth: ____/____/____ Gender : M / F ___Single ___Married ___Widowed ___Divorced

Employer _____ Location _____ PH# _____

Employer Contact Name/Title _____

► Spouses Name _____ Date of Birth ____/____/____ SS# _____

Spouses Employer _____ Wk# _____ ext _____ Cell# _____

In case of an Emergency please contact _____

Hm.PH _____ *Wk. PH* _____ *Cell PH* _____

Are you currently an active member of any branch of the United States Armed Services? Yes No
Have you recently received treatment /care for your specific injury or problem from any other medical provider? Yes No
If yes, please provide names and date last seen. _____

► PRIMARY INSURANCE CO. _____ PPO POS PCP HMO ___Card copy attached.

ID/Member# _____ Group/Plan# _____

Name on card _____ Date of Birth _____ Relation to patient _____

► SECONDARY INS. CO. _____ Card copy attached

ID/Member# _____ Group/Plan # _____

Name on card _____ Date of Birth _____ Relation to patient _____

►◇ WORKERS COMPENSATION or ◇ MOTOR VEHICLE ACCIDENT -MVA Date of Injury ____/____/____

Location / Place of Injury _____

Case Mgr. Name _____ Ph _____ Fax _____

Adjuster Name _____ Ph _____ Fax _____

Employer/Location _____ Contact _____

PATIENT INFORMATION PRO Physical Therapy
W/COMP – MVA CONT'D

Bill To: _____ Claim # _____

City _____ ST _____ Zip _____

Do you have legal representation regarding your injury? Yes No If yes, provide the name, address and phone # below.

Counsel _____ Ph# _____

Address _____

► **BENEFIT ASSIGNMENT / RELEASE OF INFORMATION** I, _____ do hereby assign all medical benefits to which I am entitled, inclusive of Medicare, private/commercial insurance, and any other health plans to PRO Physical Therapy for services rendered. I authorize PRO Physical Therapy to release all information necessary, including medical records, to assist in securing payment for services. A copy of this assignment is to be considered as valid as an original. ____/____/____.

► **PRO PRIVACY POLICY - HIPPA**

PRO Physical Therapy, LLC, maintains compliance with (HIPPA) the Health Insurance Portability and Accountability Act of 1996 privacy regulations that passed into law on December 20, 2003.

We obtain your voluntary consent to provide treatment and to release medical records to the appropriate entities who you designate to provide health care treatment, and or payment.

Our staff , both Licensed and clerical use patient information to ensure quality care, appropriate billing and reimbursement for services.

You may correct, amend, access, and request a copy of your medical record and history by signing a letter of Medical Release for the information. The cost for copies of medical records is in accordance with Virginia State law. We protect all patient information within the guidelines provided by, federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 540-636-6179.

I have read and been offered a copy of this policy.

Signature of Patient / Guardian _____ / ____/____