



Physical Therapy Works®

Date _____

Pt ID _____

√ 2007 Meade Parkway Suffolk, VA 23434 Phone 539-6300 Fax 539-0704 TDD (800)828-1120
0 1250 Smithfield Plaza Smithfield, VA 23430 Phone 357-6869 Fax 357-9531

PATIENT INFORMATION

Full Name _____ Date of Birth _____
 Address _____ SSN _____-_____-_____
 City _____ State _____ Zip Code _____
 Sex (Circle One) M F Home Phone _____
 Employer _____ Work Phone _____
 Address _____
 City _____ State _____ Zip Code _____
 Occupation _____ If Retired, Date Retired _____
 If you are a student, are you full-time or part-time? (Circle One) Full-time Part-time
 Name of School _____
 Marital Status: (Circle One) Single Married Separated Divorced Widowed
 Spouse's Information:
 Full Name _____ Date of Birth _____
 SSN _____-_____-_____ Employer _____
 If Retired, Date Retired _____

Are you eligible for coverage under the Veteran's Administration? (Circle One) Yes No

How did you hear about Physical Therapy Works, Inc.? (circle all that apply)

1. Doctor 2. Insurance Directory 3. Friend 4. Former Patient 5. Telephone Book 6. Advertisement 7. Other _____

INSURED INFORMATION

Relationship to Patient: (Circle One) Self Spouse Parent Other: _____
If SELF, skip to REFERRING PHYSICIAN INFORMATION.
 Full Name _____ Date of Birth _____
 Address _____ SSN _____-_____-_____
 City _____ State _____ Zip Code _____
 Sex (Circle One) M F Home Phone _____
 Employer _____ Work Phone _____

REFERRING PHYSICIAN INFORMATION

Physician's Name: _____ Phone: _____

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

Full Name _____ Relationship _____
 Address _____ Phone _____
 City _____ State _____ Zip Code _____

The above information is correct to the best of my knowledge:

Date _____ Signature _____

Please complete the other side of this form.

WORK RELATED INJURIES:

Provide the Date & Time of Accident: Date: _____ Time: _____
When did you first see a physician for this injury? Date: _____ Time: _____
Please provide the dates you have been unable to work in your current occupation because of your accident: From: _____ To: _____

Describe the accident: _____

Workers' Compensation Insurance

Insurance Carrier _____
Address _____
City _____ State _____ Zip _____
Claim Representative _____ Phone # _____
Claim # _____

AUTOMOBILE & OTHER ACCIDENTAL INJURIES:

Provide the Date & Time of Accident: Date: _____ Time: _____
When did you first see a physician for this injury? Date: _____ Time: _____
Describe the accident: _____

Were you injured by another party which may be held responsible? (Circle One) Yes No
Were you the driver or a passenger in the car? (Circle One) Driver Passenger
Did the accident happen on the highway or off the highway? (Circle One) Highway Off-Highway
Attorney's Name _____ Phone # _____
Attorney's Law Firm _____

NOTICE TO MEDICARE PATIENTS

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare Program Standards, Medicare will deny payment for that service.

Beneficiary Agreement

I have been notified by Physical Therapy Works, Inc. that Medicare may deny payment for some services and/or equipment provided to me. If Medicare denies payment, I agree to be fully responsible for payment of denied services.

Signature: _____ Date: _____

Do you have any concerns of your diagnosis related to your therapy that you would like to discuss with our Social Worker?
(Circle One) Yes No

ACKNOWLEDGMENT of DEEMED CONSENT

EFFECTIVE 7/1/89 THE FOLLOWING SECTION OF THE CODE OF VIRGINIA WILL APPLY TO ALL PERSONS SEEKING MEDICAL TREATMENT IN THE COMMONWEALTH OF VIRGINIA.

SECTION 32.1-45.1. Deemed consent to testing and release of test results related to infection with human immunodeficiency virus.

A. Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed. In other than emergency situations, it shall be the responsibility of the health care provider to inform patients of this provision prior to providing them with health care services, which create a risk of such exposure.

B. Whenever any patient is directly exposed to body fluids of a health care provider, or any person employed by or under the direction and control of a health care provider, in a manner which may according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus, the healthcare provider whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. Such healthcare provider shall also be deemed to have consented to the release of such test results to the person who was exposed.

C. For the purposes of this section, "health care provider" means any person, facility or agency licensed or certified to provide care or treatment by the Department of Health, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, or the Department of Social Services, any person licensed or certified by a health regulatory board within the Department of Health Professionals except for the Boards of Funeral Directors and Embalmers and Veterinary Medicine or any personal care agency contracting with the Department of Medical Assistance Services.

*** BY SIGNING BELOW YOU ARE STATING YOU HAVE BEEN MADE AWARE OF THE ABOVE VIRGINIA LAW**

Patient Signature / Legal Representative

Date

Please make your insurance card(s) available. We would like to make a copy for our files. Thank You!