VENTURE PHYSICAL THERAPY

101 Kanani Rd. Kihei, HI 96753
221 Piikea Ave. Kihei, HI 96753
628 Ilima Ave. Lanai City, HI 96793
(808) 633-4480

PATIENT INFORMATION

FIRST NAME:	LAST NAME:	MI:	NICKNAME:
ADDRESS:	CITY:	STATE:	ZIP:
DOB:	AGE:	MALE □ FEMALE □	SS#:
HOME PHONE #:		CELL #:	
EMPLOYER:		WORK #:	

EMAIL ADDRESS:

EMERGENCY CONTACT

NAME:	RELATIONSHIP TO PATIENT:
HOME PHONE #:	ALTERNATE #:

INSURANCE INFORMATION

PRIMARY INSURANCE:	SUBSCRIBER ID #:
SUBSCRIBER NAME:	DOB:
SECONDARY INSURANCE:	SUBSCRIBER ID #:

AUTO OR WORK INJURY CLAIMS ONLY

AUTO INS. NAME:		WORKER'S COMP. CARRIER:	
ADJUSTER/CLAIMS MANAGER:	PHONE #:	EXT:	
ADDRESS:	CITY:	STATE:	ZIP:
CLAIM #:		DATE OF INJURY:	

CURRENT CONDITION/CHIEF COMPLAINT:

Date of Injury: _____ Who referred you? _____

What brings you to Physical Therapy/Occupational Therapy?

How did injury occur and what have you done to treat it?

1. **CONSENT TO CARE AND TREATMENT**: I, the undersigned, do hereby agree and give my consent for Venture Physical Therapy (VPT) to provide medical care and treatment considered necessary and proper diagnosing and/or treating my condition. No treatment for any condition or disease is without side effects and physical therapy is no exception. Fortunately, with the techniques, stretches and exercises utilized by the therapists and unwanted side effects are usually rare, minor, and transient. By signing below you indicate you are aware of, and accept the risks of physical therapy treatment, and give our full consent for the therapist at Venture Physical Therapy to provide such treatment. We take great care with our patients and the resolution of your symptoms is our primary concern. Please feel free to express and concerns or questions to your therapist or to anyone of our friendly staff.
2. **FINANCIAL POLICY:** Patients must recognize that they are responsible for the charges incurred for physical therapy (Worker's Compensation excluded, although prior authorization is required.) We will submit billing claims to your insurance, free of charge for therapy services. *You are responsible for knowing what your benefits are.* In the event your insurance carrier does not submit payment for the services rendered, a statement will be issued to you for payment.
3. **MEDICARE:** Medicare's $2010 therapy cap has been repealed as of February 9, 2018. Although the cap has been lifted, therapist must still justify the patients' need for skilled Physical Therapy services.
4. **DURABLE MEDICAL EQUIPMENT (DME)/CUSTOM ORTHOTICS POLICY:** We do not bill for DME (Worker's Compensation excluded, although prior authorization is required). If your medical insurance provides orthotic benefits, we will submit billing to your insurance company. Medicare patients must sign an Advanced Beneficiary Notice (ABN) for Orthotic in the event the device is not covered. A deposit must be paid prior to ordering an orthotic.
5. **CANCELLATION AND NO SHOW POLICY:** Your scheduled appointment is a specific time when your therapist will spend time with you. Cancellations and no shows make a difference between whether you will succeed in your treatment or not. Your physician and your therapist have prescribed a set frequency and treatment. Your job is to appear for your appointment and follow your therapist's instructions and we will be able to help you achieve your goals in treatment. Failure to attend your session may hinder your recovery process as well as disrupt the schedule of your therapist.
    a. *We require a 24 hour notice in the event of a cancellation and you will be rescheduled to make up the missed appointment.*
    b. ***A $65.00 charge will be assessed for a cancellation without proper notice or for a no show. This charge is NOT covered by your insurance.***
    c. *Venture Physical Therapy reserve the right to terminate treatment if a patient cancels/misses 3 scheduled appointments. To restart your therapy you must return to your physician for a new prescription and obtain additional authorization from your insurance provider.*
6. **WORKER'S COMPENSATION & PERSONAL INJURY PATIENTS:** Documentation of any missed appointments will be forwarded to your Case Manager and Primary Care Physician. Each cancelled and no-show appointment will also be noted in your chart. Please understand that failure to actively participate in your therapy sessions may result in the impression that you are disinterested in your recovery and/or are better and able to return to work. Failure to attend therapy may jeopardize your claim. We are looking forward to working with you and ask for your cooperation.

I have read and understand the above.

SIGNATURE of Patient/Representative/Parent or Legal Guardian of Minor:	Date

MEDICAL INFORMATION RELEASE FORM (HIPPA Release Form):

If you would like us to share information or communicate with anyone besides your referring medical provider, such as other medical specialists or family members, please write their names on the line and sign below:

[ ] I authorize VPT to release protected health information to:

_____

[ ] Information is not to be released to anyone

The **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call [ ] my home [ ] my work [ ] my cell number

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

SIGNATURE of Patient/Representative/Parent or Legal Guardian of Minor:	Date

MEDICAL QUESTIONNAIRE

NAME: _____ **DATE:**_____

DO YOU NOW HAVE/OR HAVE YOU HAD ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

[ ] High Blood Pressure	[ ] Epilepsy/Seizures	[ ] Vericose Veins
[ ] Gout	[ ] Kidney Disease	[ ] Hepatitis
[ ] Chest pain	[ ] Heart attack	[ ] Dizziness/Fainting
[ ] Stroke	[ ] Asthma	[ ] Arthritis
[ ] Depression	[ ] Heart Disease	[ ] Emphysema/Bronchitis
[ ] Tuberculosis	[ ] Lung disease	[ ] Hearing Loss
[ ] Dementia	[ ] Thyroid problems	[ ] Diabetes Type I
[ ] Parkinson's Disease	[ ] Muscular dystrophy	[ ] Diabetes Type II
[ ] History of Cancer	[ ] Fibromyalgia	[ ] Fracture/Suspected Fracture
[ ] Immunosuppression	[ ] Lupus	[ ] Huntington's

[ ] Emotional/Psychological Problems: _____
[ ] Chemical Dependency (alcohol/drugs): _____
[ ] Other: _____

Allergies:_____

Surgery (include dates): _____
_____

Have you completed an advanced directive? [ ] YES [ ] NO

PLEASE INDICATE ON THE DIAGRAM WHERE YOU EXPERIENCE YOUR SYMPTOMS:

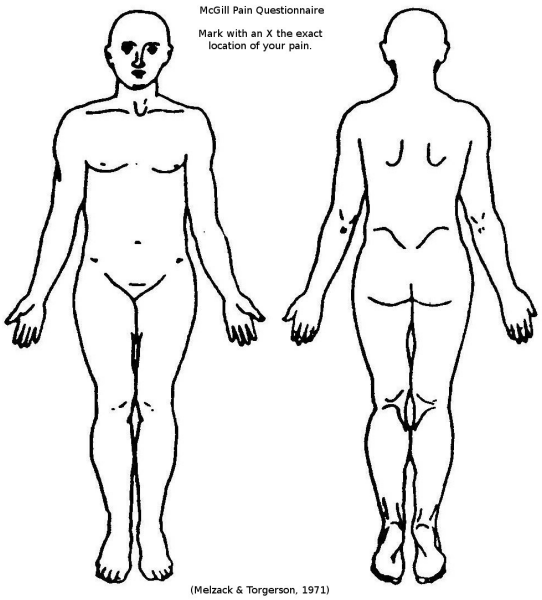
Rate your pain on a scale of 0 – 10
(0 = no pain and 10 = worse pain you can imagine):
Level of pain at its *worst*: _____
Current pain level: _____
Level of pain at its *best*: _____

Type of pain (circle):
Shooting Burning Aching Sharp Dull Tingling
Other_____

The frequency of my symptoms are:
[ ] Constant (76-100% of my day) **[ ]** Frequent (51-75% of my day)
[ ] Occasional (26-50% of day) **[ ]** Intermittent (0-25% of day)

The following test(s) have been completed for this problem:
[ ] X-ray **[ ]** MRI **[ ]** CAT **[ ]** EMG **[ ]** Bone Scan **[ ]** None

Have you had this problem before? [ ] Yes **[ ]** No
If yes, please describe:
_____
_____



Any recent falls? [ ] Yes **[ ]** No **If yes, how many?** _____ **When?** _____

Are you seeing anyone else for the problem(s)?

[ ] Acupuncturist	**[ ]** Neurologist	**[ ]** Cardiologist	**[ ]** Nursing
[ ] Chiropractor	**[ ]** Primary care physician	**[ ]** Home health services	**[ ]** Rheumatologist

[ ] Other services: _____

NAME Date

MEDICATION(S)

MEDICATION	DOSAGE	FREQUENCY	ADMINISTRATION	REASON/ DIAGNOSIS