

Personal Information			
Patient Name _____		Mr. Ms. Miss Mrs.	
Last	First	Middle	Today's Date _____
Address _____			Home Phone (____) _____
_____			Work Phone (____) _____
City	State	Zip	Mobile Phone (____) _____
Birth Date _____			Email _____
Soc. Sec. # _____			
Marital Status (<i>Circle one</i>) Single Married Other			
Emergency Contact (<i>Nearest friend or relative not living with you</i>)			
Name: _____		Phone: _____	Relationship: _____

Nature of Injury/Symptom	
Whom may we thank for referring you to this office? _____	
Primary Care Physician _____	
Date of Injury / Symptom _____	Body Part Involved _____ <i>right or left</i>
Cause of Injury _____	

Billing Information	
<i>If Other than Patient, Insurance Subscriber Information:</i>	
Patient's Occupation _____	Subscriber Name _____
Patient's Employer _____	Address _____
Employer's Address _____	_____
Spouse's Name _____	Home Phone _____
Spouse's Employer _____	Work Phone _____
Spouse's Phone _____	Subscriber's Birth Date _____
	Patient Relationship to Insured _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARD ON FILE

Please complete the following as it applies to you:

Did your injury happen at work? (*Circle one*) Yes No

Date of Accident _____ Employer at time of Injury _____

Insurance Company _____ Claim Number _____

Insurance Address _____ Insurance Phone _____

Were you involved in a motor vehicle accident? (*Circle one*) Yes No

Date of Accident _____ Insurance Company Name _____

Claim Number _____ Insurance Address _____

Ins Co. Phone _____ Are they currently paying on your claim? _____

Attorney Name _____ Attorney Phone _____

PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE ABOVE QUESTIONS

Assignment and Release: I hereby assign to Velocity Physiotherapy, LLC (VelocityPT) any and all benefits from any insurer, third party or other protection maintained for my benefit, and authorize and direct that such benefits be paid directly to VelocityPT for services provided by VelocityPT. I also authorize the release of any of my health information to any person or entity that is or may be responsible for payment for services rendered by VelocityPT, including without limitation, insurers and third party payers. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. All accounts are due and payable within 30 days. If I do not pay the balance in full within 30 days of the monthly billing date a finance charge will be added to the account of 1% per month which is an annual percentage rate of 12%. The above information is complete and accurate to the best of my knowledge and I understand and accept the information above.

Signature of Patient (or patient's authorized representative)	Relationship/ Status if signed by anyone other than the patient (e.g. parent, legal guardian, personal representative)	Date
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Acknowledgement of Receipt of Privacy Practices Notice Velocity Physiotherapy, LLC

I have been presented with a copy of Velocity Physiotherapy's **Notice of Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

We at Velocity Physiotherapy are working hard to ensure that confidentiality regarding your Protected Health Information and treatment is maintained at all times. Due to confidentiality concerns and to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, we require your signature allowing us to leave a message about your upcoming office visit, account information, or any other information you may want us to convey to you via telephone or electronic messaging.

Signature of Patient
(or patient's authorized representative)

Relationship/ Status if signed by anyone other than the patient
(e.g. parent, legal guardian, personal representative)

Date

Financial Policy

PLEASE READ CAREFULLY AND SIGN

It is your responsibility to know the limitations and restrictions of your insurance company regarding physical therapy. You are responsible for paying your balance regardless of your insurance company's payments. If your insurance company does not cover physical therapy and you opt to pay cash for treatment, your balance is due at the end of your appointment.

Signature of Patient
(or patient's authorized representative)

Relationship/ Status if signed by anyone other than the patient
(e.g. parent, legal guardian, personal representative)

Date

Missed Appointments & Cancellations: appointments not kept or cancelled, without 24 hours notice prior to the scheduled appointment time will be charged a **\$50.00** cancellation fee. These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. **This does not apply to Medicare patients.**

Signature of Patient
(or patient's authorized representative)

Relationship/ Status if signed by anyone other than the patient
(e.g. parent, legal guardian, personal representative)

Date

My copay is \$_____. Copays are due at the time of the visit.

Signature of Patient
(or patient's authorized representative)

Relationship/ Status if signed by anyone other than the patient
(e.g. parent, legal guardian, personal representative)

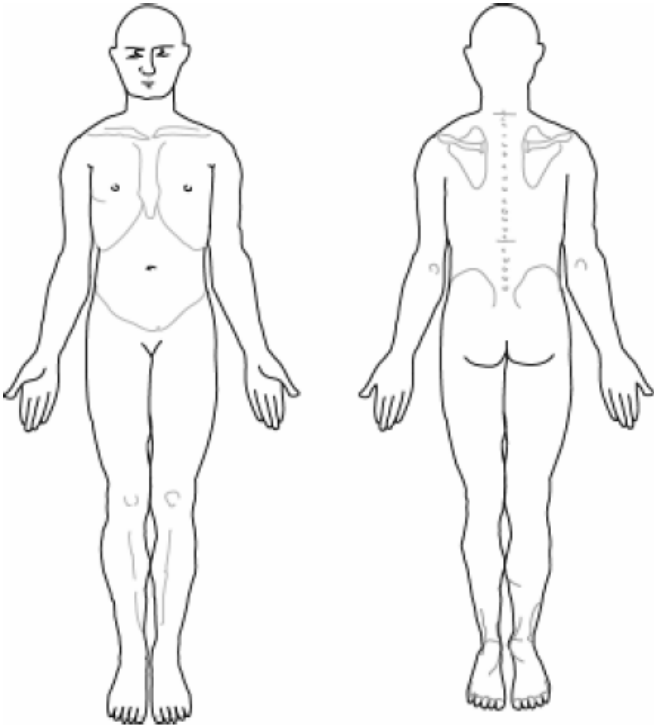
Date

General Health Questionnaire

Patient: _____ Age: _____

History of Present Condition

Locate areas of pain or abnormal sensation on the body chart below (Shade or circle where appropriate)



When did your symptoms begin? _____

Was the onset of this episode gradual or sudden?

- gradual sudden

Which of the following best describes how your injury occurred?

- lifting a motor vehicle accident
 a fall overuse
 trauma an incident at work
 degenerative process unknown
 during recreation/sports other: _____

Since onset, are your symptoms getting:

- Better Worse Not Changing

Have you had similar symptoms in the past? _____

More than one episode? _____

Nature of pain/symptoms (check all that apply)

- sharp aching constant
 dull periodic other: _____
 throbbing occasional

As the day progresses, do your symptoms:

- increase decrease stay the same

Does the pain wake you at night? No Yes

- If yes, it is present while lying still
 only when changing positions
 both

Do you have pain/stiffness upon getting out of bed in the morning? Yes No

In what position do you sleep? (check all that apply)

- right side back stomach
 left side chair/recliner other: _____

Since the onset of your current symptoms have you had:

- any difficulty with control of bowel or bladder function
 fever/chills
 any numbness in the genital or anal area
 numbness
 any dizziness or fainting attacks
 weakness
 unexplained weight change
 night pain/sweats
 malaise (vague feeling of bodily discomfort)
 problems with vision/hearing
 none of the above

What aggravates your symptoms?

- sitting repetitive activities
 going to/rising from sitting including: _____
 lying down household activities
 walking including: _____
 standing sleeping
 squatting coughing/sneezing
 up/down stairs taking a deep breath
 reaching overhead looking up overhead
 reaching in front of body swallowing
 reaching across body stress
 talking, chewing, yawning sustained bleeding
 recreation/sports other: _____

What relieves your symptoms?

- sitting rest massage
 heat standing medication
 cold walking nothing
 stretching exercise other: _____
 wearing a splint lying down _____

Have you had any previous treatment for this condition?

- none
- medication (oral)
- joint manipulation
- exercise
- massage therapy
- traction
- bracing/taping
- injection
- other: _____
- hypnosis
- biofeedback
- TENS unit
- acupuncture
- bed rest
- hospitalization
- casting
- physical therapy

Have you had any of the following tests?

- none
- X-rays
- CT scan
- MRI
- Arthrogram
- Bone Scan
- Nerve Conduction Study
- Fluoroscope
- Vestibular
- Other: _____

Test Results: _____

Medication

Please list any prescription medications you are currently taking (pain pills, injections, and/or skin patches, etc.)

Prescribing MD: _____ Phone: _____

Are you currently taking any of the following over the counter medications?

- aspirin
- Tylenol
- corticosteroids
- antihistamines
- vitamins/mineral supplements
- Advil/Motrin/Ibuprofen
- Other: _____

Previous Functional Level

Independent in all activities (work, community, home, recreation)

Self Care

- Independent in all self-care activities (bathing, toileting, dressing, etc.)
- Difficulty performing self-care activities
- Need assistance with self-care activities
- Difficulty performing household chores

Social

- Need assistance with activities in community outside of home

Hobbies: _____

Work History

Occupation: _____

Physical activities at work (*check all that apply*)

- sitting
- standing
- phone use
- repetitive/heavy lifting
- computer use
- heavy equipment operation
- driving
- other _____

Are you currently receiving or seeking disability for this condition? Yes No

If not performing your normal activities at work do you plan to return to your previous activity level?

- Yes
- No

General Health

How would you rate your general health?

- Excellent
- Good
- Average
- Fair
- Poor

Do you exercise outside of normal daily activities?

- 5+ days/wk
- 3-4 days/wk
- 1-2 days/wk
- occasionally
- zero

Exercise, sports/recreation consisting of: _____

Do you drink caffeinated beverages?

- No
 - Yes
- How many/much per day? _____

Do you smoke?

- No
 - Yes
- Packs of cigarettes per day _____

What is your stress level?

- Low
- Medium
- High

Are you seeing any health care providers other than the physical therapist for this current condition? (*Please list*)

Past Medical History

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- Cancer (type) _____
- Depression
- Stroke
- Kidney problems
- Thyroid problems
- Diabetes
- Multiple sclerosis
- Arthritis
- Head injury
- Stomach problems
- Parkinson's disease
- Infectious diseases
- Heart problems
- High blood pressure
- Lung problems
- Blood disorders
- Epilepsy/seizures
- Allergies
- Rheumatoid arthritis
- Osteoporosis
- Broken bone
- Circulation/vascular problems
- Other: _____
(i.e. hepatitis, tuberculosis, etc.)

Please list any recent/relevant past surgeries related to your current problem:

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



Velocity Physiotherapy, LLC Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Velocity Physiotherapy Legal Duty

Velocity Physiotherapy, LLC (VelocityPT) is required by law to protect the privacy of your personal health information, provide this notice about your information practices, and the following information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Velocity PT uses your personal health information primarily for treatment, obtaining payment for treatment, conduction internal administrative activities, and evaluating the quality of care that we provide. For example,

Velocity PT may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefit that could be of interest to you.

Velocity PT may also use or disclose your health information without prior authorization for public health purpose, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information required by law.

In any other situation, Velocity PT's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Velocity PT may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we do not use or disclose your personal health information, treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. VelocityPT will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that VelocityPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address below. You may also send a written complaint to the US Department of Health and Human Services. For further information on VelocityPT's health information practices, or if you have a complaint, please contact the following office:

HIPAA Compliance Office
Velocity Physiotherapy, LLC
1037 NE 65th St, #115
Seattle, WA 98115
(206) 905-8575