

VOLK PHYSICAL THERAPY

PATIENT INFORMATION

Last Name: _____ First: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

Person Financially Responsible / Relationship: _____

Gender: M _____ F _____ Date of Birth: _____ SS#: _____

Marital Status: M _____ S _____ D _____ W _____ Spouse's Name: _____

Employer's Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Onset: _____ Is this problem related to: Work? _____ Auto Accident? _____

Referring Dr. _____ Body Part to Be Treated: _____

Emergency Contact / Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Policy Holder's Last Name: _____ First: _____ MI: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Date of Birth: _____ Relationship to Patient: _____

Policy Holder's Employer: _____

Policy #: _____ Group #: _____ Phone: _____

Secondary Insurance Company: _____

Policy Holder's Last Name: _____ First: _____ MI: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Date of Birth: _____ Relationship to Patient: _____

Policy Holder's Employer: _____

Policy #: _____ Group #: _____ Phone: _____

236 LePhillip Court, Suite A
Concord, NC 28025

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Worker's Comp / Auto Insurance Company: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Claim #: _____ Phone: _____

Adjuster's Name: _____ Phone: _____

Date of Injury: _____ Is there an attorney involved? _____

MEDICAL HISTORY

Have you had any of the following?-----*(Circle y or n)*

High Blood Pressure	y n	Pregnancy (current)	y n	Metal Implants	y n
Heart Attack	y n	Allergies	y n	Previous Surgery	y n
Heart Disease	y n	Hernia	y n	Fever	y n
Pacemaker	y n	Seizures	y n	Cancer	y n
Headaches	y n	Sensitive to heat or ice	y n	Nervous Disorders	y n
Kidney problems	y n	Night Pain	y n	Diabetes	y n

Please list current medications:

Please give a brief explanation and dates for any area marked yes:

Who may we thank for referring you to us? _____

Consent to Treat and Authorization to Release Information

I consent to evaluation and treatment by Volk Physical Therapy, LLC, and realize that I have the right to refuse any procedure. I authorize the release of information acquired in the course of my treatment, including, but not limited to medical records, electronic media and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payers. I authorize payments of medical benefits directly to Volk Physical Therapy, LLC. I acknowledge that I am ultimately responsible for all charges for services rendered by Volk Physical Therapy, LLC. I agree to pay all copays and other payments required according to my insurance policy, unless other arrangements have been made. If Volk Physical Therapy, LLC is in-network with my insurance company, this guaranty includes charges for services not covered by my insurance, regardless of the reason that insurance coverage is denied. If I fail to pay all charges and Volk Physical Therapy, LLC uses an attorney to collect unpaid charges, I agree to pay the reasonable cost of the attorney's services in addition to the unpaid charges. I authorize phone messages regarding my treatment and appointments to be left with persons or machines/voice mail at the phone numbers I have provided above. A copy of the facility's Statement of Privacy Notice has been made available to me.

Patient Signature: _____ Date: _____
(Or Responsible Party)