

Valley Physical Therapy

Date_____

Legal Name_____ Nick Name_____

Mailing Address_____ City_____ Zip_____

Street Address (if different)_____

Social Security #_____ Home Phone ()_____ Work Phone ()_____

Driver's License#_____ Date of Birth_____ Email_____

Marital Status: **Single** **Married** Spouse's Name_____

In case of Emergency call (name & phone #)_____

Your Occupation_____

Employer_____ Phone ()_____

Employer Address_____

Name of person who referred you_____

Physician treating this condition_____ Phone ()_____

Address_____

Please describe your injury or pain:

Location on body_____ Is it now: better, worse, or the same?

Describe how you were injured/pain began_____

When did this first begin_____

How have you been treating this injury?_____

Please list your current: Medications_____

Medical conditions_____

Any surgeries you have had_____

over, please

Valley Physical Therapy

Date_____

I will be billing this claim through my (circle one):

Private Ins. (i.e. Blue Cross, Blue Shield, Aetna, etc.) **Medicare** **Worker's Compensation**
Auto Insurance **Other**

Name of insured if other than yourself (Guarantor)_____

Guarantor's SS#_____ Guarantor's Date of Birth_____

Relationship to you: **Spouse Parent Child Other**

Guarantor's Address if different than yours: Street_____

City_____ State_____ Zip_____

Please provide us with your insurance cards so we may make a copy

Please read and initial each of the following statements

Initials

_____ I understand that I have been referred to physical therapy for treatment and that this treatment may involve exercises, instruction in movements, manual techniques (the therapist using hand contact), as well as applications of heat, cold, electrical current or other modality of treatment. I understand that no guarantee or assurance has been, nor can be made by Valley Physical Therapy as to the results of the prescribed treatment and that my complete participation is required for optimal results to occur. I understand I am encouraged to ask questions as they arise.

_____ The state of California requires you have a diagnosis from a physician before you can receive physical therapy treatment. A physical therapist can evaluate you without a diagnosis from a physician, however, cannot provide treatment.

_____ I understand that I am personally responsible for all charges incurred by me or my dependant at Valley Physical Therapy.

_____ **I understand that a \$40 fee will be charged directly to my credit card on file for appointments cancelled with less than 24 hour notification. (Chronic no shows and late cancellations will be dealt with on a case-by-case basis and may result in you no longer being able to receive services at our office.)**

I certify that the above information is true and correct to the best of my knowledge. I will inform Valley Physical Therapy of any changes in this information if it should occur during the course of my treatment.

Signature_____ Date_____