VICTORY
REHABILITATION

Personal and Contact Information

First Name: _____ Last Name: _____ Date of Birth: _____

Gender: M F Name Preference: _____

Address: _____ City: _____ State: _____

Mobile Phone: _____ Email: _____

Are you using insurance? Y N Insurance: _____

Member ID: _____

Are you working with an attorney? Y N

If so, please give us your attorney's information below:

Name: _____
Phone Number: _____
Email Address: _____

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Injury Details

What date did you first experience symptoms related to your injury? _____

If you had surgery for this issue, what was the date of the most recent surgery?
_____

Have you treated elsewhere? If so, where? _____

Medical History

Have you ever suffered from or been told you have any of the following?

	Yes	No		Yes	No
High blood pressure			Heart problems		
Lung problems			Head injury		
Multiple Sclerosis			Parkinson's Disease		
Stroke			Liver problems		
Thyroid problems			Blood disorders		
Diabetes			Low blood sugar		
Cancer			Arthritis		
Osteoporosis			Circulatory or vascular problems		
Broken or fractured bones			Other orthopedic problems		
Chronic pain			Ulcers/stomach problems		
Chronic Migraines					

Please list any medications you are currently taking: _____
_____

Victory Rehabilitation Patient Authorization and Consent to Treat

I hereby consent to treatment.

I authorize Victory Rehabilitation, LLC and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

I have received Victory Rehabilitation, LLC's Notice of Information Practices. I understand that Victory Rehabilitation, LLC and its subsidiaries and affiliates may use or disclose my personal health information to my insurance company, rehabilitation nurse, case manager, attorney, employer, school related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment. I understand that I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that Victory Rehabilitation, LLC will consider requests on a case-by-case basis, but does not have to agree to requests for restrictions.

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize the payment of medical benefits directly to Victory Rehabilitation, LLC for the services rendered. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered effective and valid as the original.

I hereby authorize one or all of the designated parties below to request the release of and receive any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name and Relationship: _____

Name and Relationship: _____

Payment Guarantee: I agree to pay Victory Rehabilitation, LLC its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as Workers' Compensation or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Victory Rehabilitation, LLC and/or its affiliates or subsidiaries.

Patient Name: _____

Signature: _____ Social Security Number: _____

Terms and Conditions

Making Changes to Your Physical Therapy Appointment:

Our office requires a 24 hour notice to make any changes to your appointment. We reserve that time just for you. Any changes need to be made by calling and speaking to one of our office staff. If a staff member does not answer the phone, please leave a voicemail. If you fail to speak with a staff member to cancel your appointment and do not show, you will be charged a $25.00 no show fee.

Health Insurance:

Health insurance is a contract between you and your insurance company. We file insurance as a courtesy to the patient and estimate what your insurance co-pays and co-insurances are according to your benefits breakdown acquired from your insurance. This does not guarantee benefits will be paid or paid at the estimated amounts. You are the responsible party and are always responsible for any amounts that your insurance does not cover. If you do not agree with what or how they have paid on your claim, you will need to contact your insurance company to discuss. We will not do this for you.

It is a federal requirement that the correct patient insurance card and picture ID be provided to us at your visits. Without these, we will not provide service and you will be charged a no show fee. If you fail to provide the correct insurance card, you will be held responsible for the cost of service.

It is your responsibility to make sure you have authorization to be seen by our office by making sure your referral is not expired and that you have enough visits left on it to cover your visit. Our office tries to help in tracking this but ultimately, this is the patient's responsibility.

Co-pays:

Co-pays are due at the time of your appointment.

Patient Name: _____

Signature: _____