Welcome
Thank you for choosing Valir as your health care provider!

Please complete the following information:

Patient Name:		Patient/Guarantor Cell Phone:	
Patient Address:		Patient/Guarantor Home Phone:	
Patient City / State / Zip:		Patient/Guarantor Work Phone:	
Date of Birth:		Patient Email:	
Social Security Number:		Gender:	___ M ___ F ___ O
Employer Name:		Marital Status:	___ S ___ M ___ W ___D ___ O
Employer Address:		Emergency Contact Name:	
Employer City / State / Zip:		Emergency Contact Phone	

Please complete the following information regarding the Guarantor (person responsible for payment):

Guarantor Name:		Guarantor Phone:	
Guarantor Address:		Guarantor Date of Birth:	
Guarantor City / State / Zip:		Guarantor Social Security #:	
Guarantor Employer:		Guarantor Employer Address:	
Employer Address:		Employer City / State / Zip:	

Please complete the following information related to accident or job related injuries:

Were you involved in an MVA or Personal Injury Accident?	____ Yes ____ No	Date of Injury:	
Is your injury work related or did it occur on the job?	____ Yes ____ No	Date of Injury:	
Attorney Name and Law Firm:		Attorney Address:	
Attorney Phone:		Attorney Fax:	

*****Have you received home health services in the last sixty days?*** YES // NO**
If yes, list the name of Home Health company? _____ Phone Number: _____

Please read the following statement, sign and date form.

I understand and agree that health and accident insurance policies are a contract between an insurance carrier and the policy holder/insured. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that any amounts that are patient due are due on the date of service. I also certify that the above information is true and correct to the best of my knowledge. I understand that missing a scheduled appointment without providing 24 hour notice to this office will result in a $35.00 charge that will be due at my next appointment. My signature below also certifies that I have received a copy of Valir's Notice of Privacy Practices (effective 01.01.2017).	
Patient / Guarantor Signature:	Date:

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Insurance Verification Worksheet

Valir Tax ID #:	20-148-8879	Valir Group NPI #:	198-268-3306
Patient Account Number:		Call Reference #:	
Patient Name:		Patient Date of Birth:	___/___/___
Person Verifying:		Date and Time Called:	___/___/___ @ __:__ am/pm

Coverage and Benefit Information (Commercial Payers):

Member ID Number:		Group Number:	
Spoke with:		Ins. Phone Number:	Ext. ___
Policyholder Name:		Policyholder DOB:	

In Network Benefits: Effective Date: _____ **Family Benefits // Out of Network:**

Deductible:	_____ / _____ met	Deductible:	_____ / _____ met
Out of Pocket Max:	_____ / _____ met	Out of Pocket Max:	_____ / _____ met
Coinsurance Amount:	_____ / _____ %	Coinsurance Amount:	_____ / _____ %
Patient Copay Amount:	$ _____ per visit	Patient Copay Amount:	$ _____ per visit

Max Visit Limit PCY:	_____ / _____ used	Is Auth Required?	____ Yes ____ No
Is Visit Limit Hard Limit?	____ Yes ____ No	Authorization Number:	
Max Payable PCY:	_____ / _____ Used	# of Visits Authorized?	
Referral Required?	____ Yes ____ No	Auth Date Range:	
Coverage BMN?	____ Yes ____ No	Pre Cert Phone #:	
Secondary coverage?	____ Yes ____ No	Secondary Payer:	

Worker's Compensation:

Claim Number:		Date of Injury:	
Adjustor Name:		Adjustor Phone #:	Ext. ___
Nurse Case Manager:		NCM Phone #:	Ext. ___
# of visits authorized:		Authorization #:	
Body Part(s) Authorized?			

Claims Mailing Address (Verify Claims Address Every Time)

Payer Name:	
Payer Address / PO Box:	
City / State / Zip	

The office staff have explained my benefits to me. I understand when the insurance company verifies my benefits it is not a guarantee or authorization to pay on claims submitted. I agree to pay my portion (which is only an estimate) at the time of service. I agree to pay/settle any denied and unpaid claims. I understand any patient due portion is due in full upon notification from this office. I may have to pursue reimbursement directly from the insurance company or third party payer. Please sign, print name and date below.

Patient Signature:		
Patient Name:		Date of Signature: ____ / ____ / _____

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Patient Name:
Date of Birth:

Disclosure of Information
I understand that my medical records and billing information are made and retained by Valir Physical Therapy and are accessible to Valir Physical Therapy's personnel, who may use and disclose medical information for Valir Physical Therapy operations and functions and to any other health care personnel, involved in my continuum of care for this admission.

Release of Records
I authorize Valir Physical Therapy to release to any governmental health care program and its agents, or to any private insurance company or its agents any information needed to determine my benefits or the benefits payable for Valir Physical Therapy.

I hereby authorize my attending physician to release all medical records pertaining to my healthcare information to Valir Physical Therapy. I understand further, the information, authorized for release may include records which may have the presence of a communicable or venereal disease which may include, but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Acknowledgement of Notice of Privacy Practices
A complete description of how my medical information will be used and disclosed by Valir Physical Therapy has been given to me in Valir Physical Therapy's NOTICE OF PRIVACY PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this Consent Form. If I have any questions, I know to contact the Compliance Officer whose information is provided to me in the Notice of Privacy Practices.

Consent for Care and Treatment
I, the undersigned, do hereby agree and give my consent for Valir to furnish medical care and treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition.

Appointment Reminders
Complete and sign below to give your permission for Valir Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

Select One Appointment Reminder Option Below:

☐ Valir Physical Therapy may send email messages to confirm my upcoming appointments to email address: _____.

☐ Valir Physical Therapy may send cell phone text messages to confirm my upcoming appointments to phone number: _____.
I recognize that normal text messaging rates may apply.

*****MUST LIST CELL PHONE CARRIER (ATT/SPRINT/VERIZON…ETC)*****
_____

☐ I do not wish to receive appointment reminders at this time.

Patient Name **Date of Birth**

Patient Signature (Parent/Guardian/Legal Representative) **Date**

Relationship to Patient

Witness Signature **Date**

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VALIR PHYSICAL THERAPY - FINANCIAL POLICY

INSURANCE INFORMATION We need complete and accurate information about your policy. As a courtesy, Valir will call the provided insurance company to verify eligibility and benefits. However, this will not be a guarantee of eligibility and benefits. Please contact your insurance company with any questions you may have regarding your coverage.

NON-INSURANCE-FEE-FOR-SERVICE (Self-Pay) Fee-for-service is exclusively a non-insurance financial arrangement. Fee-for-service receipts cannot be submitted to insurance for reimbursement. VALIR will discount charges to reflect the current Medicare Allowable Fee Schedule. ***To be eligible for this discount, full payment must be received at the time services are rendered. If full payment for the services rendered is not received at the time of service, the discount will be reversed and 100% of the billed charges will be billed to the patient.***

WORKER'S COMPENSATION Valir requires approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

MEDICARE Valir Physical Therapy participates with Medicare and we bill Medicare as well as any supplemental insurance company provided. Physical therapy is covered service up to $2040.00 per calendar year. After the initial $2040.00 has been surpassed, Medicare could cover physical therapy (with proof of medical necessity) up to $3000.00. You are responsible for any copayment, co-insurance or deductible that applies to your plan.

MINORS *A parent or legal guardian must accompany the minor patient at the time of the initial visit.* The parent of legal guardian is responsible for full payment as outlined in the above financial policy. If the parents are separated and both legally responsible for the child, you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

PERSONAL INJURY, LIABILITY, AUTO OR INVOLVEMENT OF AN ATTORNEY Patients with a Personal or MVA injury that wish to file their claims with the liable party must provide to us their personal health insurance or med pay insurance from their own motor vehicle insurance policy in addition to the plan information from the liable party. If you do not provide your personal insurance or med pay, you must pay $100.00 per visit.

VALIR will also file a lien for any balance on your account that is not paid at the time services are rendered.

PAYMENT Valir accepts cash, check, American Express, VISA, MasterCard and Discover. There will be a $35.00 service charge for all returned checks. If you have insurance, balances will be considered current from the date your insurance pays its portion. After that, there is a 60-day grace period to pay your portion of the services. After the 60-day period a 1.5% (18% APR) late charge may be assessed on all unpaid balances. We will work with you to set-up a custom payment plan if necessary, please ask. Account balances over 60 days without a payment or payment agreement will be subject to assignment to an out of office collection assistance agency.

COLLECTIONS FOR PAST DUE ACCOUNTS Valir will work with you to avoid sending your account to collections. In the event of default on your account, your account will be turned over to a collection agency. You will be responsible for the unpaid balance plus a collection fee of 23% based on your unpaid balance. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

By signing below, I am agreeing that I have read and understand the above outlined financial policy of VALIR and understand my financial responsibility for the services rendered to me by VALIR. I also understand that once I have signed this agreement, I am stating that I agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. I also agree that Valir and their business associates may contact me and all other responsible parties on my account, on our cell phones or mobile devices concerning any and all aspects of my account.

_____	_____	_____	_____
Signature of Patient or responsible party	**Date of Birth**	**Printed Name of Patient or responsible party**	**Date**

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Patient Health Questionnaire – PHQ

Patient Name: _____

DOB:_____

Date: _____

Referring Physician: _____

Primary Care Physician: _____

1) Describe your symptoms:

_____

_____

   a. When did your symptoms start?

   _____

   b. How did your symptoms begin?

   _____

2) How often you experience your symptoms. **(circle one)**
   1. Constantly (76-100% of the day)
   2. Frequently (51-75% of the day)
   3. Occasionally (26-50% of the day)
   4. Intermittently (0-25% of the day)

3) How are your symptoms changing? (**circle one**)
   1. Getting Better
   2. Not Changing
   3. Getting Worse

4) During the past (4) weeks:
   a. Indicate current pain level:
   0 1 2 3 4 5 6 7 8 9 10
   b. Indicate minimum pain level:
   0 1 2 3 4 5 6 7 8 9 10
   c. Indicate maximum pain level:
   0 1 2 3 4 5 6 7 8 9 10

5) How much has pain interfered with your normal work, inside and outside the home? (**circle one**)
   1. Not at all 3. Quite a bit 5. Extremely
   2. A little bit 4. Moderately

6) How much has your condition interfered with social activities? (**circle one**)
   1. Not at all 3. Quite a bit 5. Extremely
   2. A little bit 4. Moderately

7) What describes the nature of your symptoms? (**circle all that apply**)
   1. Sharp 3. Shooting 5. Dull Ache
   2. Burning 4. Numb 6.Tingling

8) In general, would you say your overall health right now is: (**circle one**)
   1. Excellent 3. Fair
   2. Very Good 4. Poor

9) Who have you seen for your symptoms? (**circle all that apply**)
   1. No One 3. Chiropractor 5. Other
   2. PT 4. MD

   a) What treatment did you receive and when?

   _____

   b) What tests have you had for your symptoms and when?

   _____

10) Have you had similar symptoms in the past? (**circle one**) Yes // No

11) What is your expected outcome from physical therapy?

_____

12) What is your occupation? _____
(**circle one**)
FT PT Unemployed Retired Off Work

13) Current Weight: _____ Height: _____

Patient Signature:

_____

Date: _____

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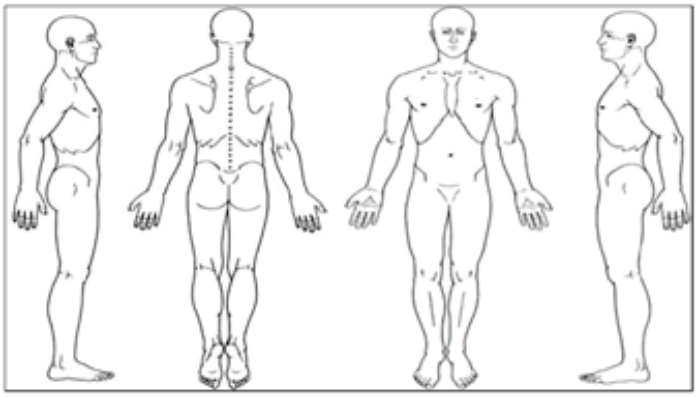

Indicate with 'X' where you have pain or other symptoms.

Please list all allergies and/or medications you are taking with dosages (if applicable), including over the counter, vitamins and supplements.

Do you now have, or have you ever had, any of the following medical conditions?

☐ Asthma/Bronchitis/Emphysema/COPD	☐ Blood Clot / Embolism	☐ Unexplained Night Pain	☐ Anemia
☐ Shortness of Breath / Chest Pain	☐ Epilepsy / Seizures	☐ Osteoporosis	☐ Weakness
☐ Coronary Heart Disease or Angina	☐ Thyroid Disease / Goiter	☐ Arthritis	☐ Hernia
☐ Pacemaker / Defibrillator	☐ Bowel/Bladder Problems	☐ Severe/Frequent Headaches	☐ Varicose Veins
☐ Cancer / Chemo / Radiation	☐ Diabetes	☐ Vision/Hearing Difficulties	☐ Allergies
☐ Heart Attack / Heart Surgery	☐ Infectious Disease	☐ Numbness / Tingling	☐ Pins/Metal Implants
☐ Unexplained Weight Loss / Energy Loss	☐ High Blood Pressure	☐ Dizziness / Fainting	☐ Gout
☐ Congestive Heart Disease	☐ Stroke / TIA	☐ Sleeping Difficulties	☐ Pregnant
List Surgeries:		☐ Use Tobacco? How Much? _____	☐ Emotional / Psychological

Other medical condition(s) that you would like to bring to our attention? _____

Patient Signature: _____ **Date:**