



Patient Name: \_\_\_\_\_

**Privacy Policy**

I HAVE BEEN MADE AWARE OF THE PRIVACY POLICY (HIPAA COMPLIANCE) OF Velocity Spine & Sports AND HAVE BEEN GIVEN THE OPPORTUNITY TO ADDRESS THESE ISSUES IF NEEDED

**Release of Medical Records**

I authorize the release of information to the following entities involved in my care:

- All insurance companies
- Physicians
- Attorneys (if applicable)

**Consent for Treatment**

I authorize VELOCITY to examine me and evaluate my condition and to perform the treatment of physical therapy and/or comprehensive rehab treatment.

**Assignment of Benefits**

I authorize and request that insurance payments be made directly to Velocity Spine and Sports PT.

**Financial Agreement**

I acknowledge full responsibility for services rendered at Velocity Spine and Sports Physical Therapy.

I understand that payment of the patient's co-pay or coinsurance is due at the time of service.

I agree to give **24 hour notice** in my inability to keep scheduled appointments, (except in the case of an emergency situation) so that VELOCITY can offer effective scheduling practices.

**I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, privacy information, and insurance authorization.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

**Patient Name:** \_\_\_\_\_

### Medical History

**Please check if you have EVER had(Circle):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ulcers/Stomach Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Spitting Up Blood             |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Fractures        | <input type="checkbox"/> Lung Problems                 |
| <input type="checkbox"/> Repeated Infections     | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Cancer                        |
| <input type="checkbox"/> Rectal Bleeding         | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> High Blood Pressure           |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Infectious Disease            |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Circulation/Vascular Problems |
| <input type="checkbox"/> Seizures/Epilepsy       | <input type="checkbox"/> Blood Disorders  | <input type="checkbox"/> Other _____                   |

**Within the past year, have you had any of the following symptoms? (Circle all that apply.)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Heart Palpitations       |
| <input type="checkbox"/> Bowel Problems         | <input type="checkbox"/> Loss of Appetite    | <input type="checkbox"/> Dizziness/Blackouts      |
| <input type="checkbox"/> Urinary Problems       | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Coordination Problems    |
| <input type="checkbox"/> Weight Gain or Loss    | <input type="checkbox"/> Sleep Problems      | <input type="checkbox"/> Persistent Hoarseness    |
| <input type="checkbox"/> Persistent Coughing    | <input type="checkbox"/> Pain at Night       | <input type="checkbox"/> Coordination Problems    |
| <input type="checkbox"/> Joint Pain or Swelling | <input type="checkbox"/> Vision Problems     | <input type="checkbox"/> Weakness in Arms or Legs |

Have you ever had surgery? Yes No

If yes, describe and include dates:

Year

_____	_____
_____	_____
_____	_____

Reason for Physical Therapy visit: \_\_\_\_\_

Previous Treatment for this condition (circle): Physical Therapy    Chiropractic    massage  
injection    acupuncture    other \_\_\_\_\_

Tests for this condition: MRI      CT Scan      Bone Scan      X-ray      EMG

List any other factors we should consider when evaluating your case:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Therapist's signature

\_\_\_\_\_  
Date