

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Thank you for choosing Spine and Orthopedic Rehab of Virginia (SORVA) as your Physical Therapy provider.

Please make sure the **provided forms** **are fully completed prior to arriving** for your initial appointment.

Please arrive at\_\_\_\_\_\_\_\_ for your initial appointment reserved for \_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_. **Failure to arrive at the correct time may compromise your evaluation and possibly result in rescheduling.**

You should anticipate spending 1.5 to 2 hours total at your initial appointment on the first day, with subsequent sessions lasting approximately one hour. If you are experiencing dizziness, it is recommended that you bring a driver along should you need assistance following the evaluation.

You are required to bring the following documents for your initial evaluation:

* Physical Therapy Prescription from your physician (unless you confirm that it has already been faxed to us by your referring medical provider); however, if you are utilizing “direct access” to physical therapy, a physical therapy prescription is not required
* Insurance Card/Cards (primary AND secondary insurance cards if applicable)
* Driver’s License or a Valid Picture ID
* Required forms **completed**

**Failure to present these items at the time of your initial evaluation may result in rescheduling**.

Please wear (or at least bring with you) loose fitting clothing such as shorts, t-shirt, and tennis shoes allowing the physical therapist to evaluate and treat you in the most effective and safe manner.

We look forward to assisting you with your physical therapy needs! If you have any questions or concerns prior to your first visit, please do not hesitate to contact one of our two conveniently located offices.

Sincerely,

SORVA Staff

**Patient Registration Form**

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

First MI Last **(\*name as it appears on insurance card\*)**

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email\*\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Your email is used only for the purposes of SORVA and NLW (wellness subsidiary) communication and **will not be** sold/given to any other party.

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Gender M F Marital Status Married Single Divorced Widowed

Phone Home (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next MD Appt. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

First Last (…..office use only…..)

Primary MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next MD Appt. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

First Last

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had Physical Therapy this calendar year? Yes \_\_\_\_\_ No \_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Are you currently receiving chiropractic services? Yes \_\_\_\_\_ No \_\_\_\_\_\_
* Are you currently receiving **ANY** home health care/benefits? Yes \_\_\_\_\_ No \_\_\_\_\_\_

Is injury due to an accident? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Auto accident (if yes, in which state did the accident occur)? Yes\_\_\_\_\_ State\_\_\_\_\_\_ Work related\_\_\_\_\_ Personal \_\_\_\_\_

Is an attorney involved? Yes \_\_\_\_ No \_\_\_\_\_ If Yes, please provide the information below.

Attorney Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Firm Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Firm Phone (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

***Primary*** Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_Self \_\_\_\_\_Spouse \_\_\_\_\_Parent \_\_\_\_\_Other (explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

***Secondary*** Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_Self \_\_\_\_\_Spouse \_\_\_\_\_Parent \_\_\_\_\_Other (explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Patient History Form**

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

Do **you** have a history of the following? Check either Y for yes or N for no for **every** item. If you checked Y, please briefly explain in the space provided to the right.

Y N Y N

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Cancer |  |  |  | Thyroid Disease |  |  |  |
| Headache |  |  |  | HIV |  |  |  |
| Asthma |  |  |  | Heart Disease |  |  |  |
| Diabetes |  |  |  | High Blood Pressure |  |  |  |
| Seizures |  |  |  | Circulation |  |  |  |
| Fractures |  |  |  | Pacemaker |  |  |  |
| Sprains/strains |  |  |  | Bladder |  |  |  |
| Joint replacement |  |  |  | Digestion |  |  |  |
| Metal implants |  |  |  | Weight loss/gain |  |  |  |
| TMJ/Jaw pain |  |  |  | Night pain |  |  |  |
| Dizziness/Vertigo |  |  |  | Osteoporosis |  |  |  |
| Are you pregnant? |  |  |  | Hepatitis |  |  |  |
| Stroke |  |  |  | Smoker |  |  | Packs/day:\_\_\_\_ Yrs:\_\_\_\_ |

Please list any other health problems not described above. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Please list all medications/supplements, exact dosages and reason for its use (may provide your own document).

Medication Dosage Reason Medication Dosage Reason

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

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

Please list all surgical interventions and the year in which they were each performed. Use another sheet if necessary, or provide your own document if preferred, listing the affected right or left side of the body if applicable.

Surgery Year Surgery Year

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

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

Do you exercise? If so, please take a moment to complete the following:

Cardiovascular: (circle - walk run bike elliptical hike) I do this \_\_\_\_\_ days/week for \_\_\_\_\_ minutes/day

Weightlifting: I do this \_\_\_\_\_ days/week for \_\_\_\_\_ minutes/day

Stretching: I do this \_\_\_\_\_ times/day \_\_\_\_\_ days/week for \_\_\_\_\_ minutes/day

Yoga: I do this \_\_\_\_\_\_days/week

Pilates: I do this \_\_\_\_\_\_ days/week

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation Policy**

A recommendation of visit frequency per week is made by the evaluating physical therapist based upon the initial examination to maximize your specific outcome potential. Absence at your physical therapy sessions will impede your recovery.

It is our responsibility and desire to expedite your recovery. This can only be accomplished by your consistent motivation and perseverance. Patients who do not show for their appointments (or frequently cancel) demonstrate a lack of motivation or lack the commitment necessary for a positive result from physical therapy.

We understand that unexpected events arise from time to time. It is rare that we are unable to reschedule an appointment for you to maintain the recommended visit frequency. Please notify SORVA at your earliest convenience should you need to adjust your reserved appointment time.

Patients who do not show up or fail to cancel with at least 24 hours of notice for reserved appointments will be assessed a $35 fee which will appear on their next statement. If a patient does not show up for two or more reserved appointments, that patient may be discharged and the referring physician notified of non-compliance.

I have read and do understand SORVA’s Cancellation Policy.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dry Needling Waiver**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that dry needling is not acupuncture, but does involve acupuncture needle insertion into specific regions of soft tissue during treatment to reduce pain. I understand that dry needling should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. I also understand that there is no injection of any material of any kind into my body, as the acupuncture needles are solid and cylindrical in form (not hollow, as would be used to inject medication).

Although the risk of serious harm is minimal, I understand that there is the possibility of side effects. Insertion of acupuncture needles into the body could possibly result in the puncture of an organ such as the lung, the puncture of a vessel (artery or vein) or an injury to a nerve. Hematomas may occur and bruising may result. It is possible that I may experience stimulation of the sympathetic nervous system which may include the following: feeling hot, dizzy, nauseous or faint during and possibly for a short time after dry needling.

I understand the risk of complications though small is real. I hereby hold the trained and dry needling certified Physical Therapists Eric Reichardt MPT, Angela Reichardt MPT, Jed Gorman DPT, Daniel Beale DPT, and SORVA harmless for any injury sustained from dry needling during the course of my treatments.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*If refusing dry needling, please sign here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of Privacy Notice**

*Effective June 1, 2003*

THIS PRIVACY NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND

DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

We may contact you by phone, mail, or email. It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

* You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
* You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
* You have the right to inspect and copy your health information.
* You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
* You have a right to receive an accounting of disclosures of your protected health information made by us.
* You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact us by calling our office at (540) 985-6500. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information, should be directed to our Privacy Officer by calling our office at (540) 985-6500. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

HHS, Office of Civil Rights

200 Independence Avenue, S.W.

Room 509F HHH Building

Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Spine and Orthopedic Rehab of Virginia, Inc with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in this Privacy Notice.

Patient’s Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Patient’s Signature Date

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

Authorized Facility Signature Date



**OFFICE POLICIES**

1. We ask that you arrive early so that your therapist remains on schedule. Please call the office to notify us if you are going to be late. Failure to arrive in a timely manner for your reserved appointment may result in a shortened treatment session and subsequent lack of expected progress.
2. Please limit your use of cell phones in the office to emergency calls as this disturbs other patients as well as your own treatments.
3. Patients required to make co-pays by their insurance companies are expected to make their co-pays upon each visit. Patients with co-insurance are expected to make at least $35 in payments each week towards their account balance. If you have a primary insurance (Medicare for example) with a secondary insurance that has been verified to pay the remainder of the balance, you do not need to make payments as long as your deductibles have already been fully met. The SORVA staff performs a courtesy insurance benefits verification to request your insurance company’s reported benefits for outpatient physical therapy services; however, the information reported to us by your insurance company is not a guarantee of payment, so we highly recommend that you also verify your benefits with your insurance carrier. Ultimately, it is your responsibility to know what your benefits do/do not cover.

1. Patients who do not show for their reserved appointment or give short notice of cancellation (<24 hours) will be assessed a $35 fee which will appear on their next billing statement.
2. Please reserve your appointments in advance and verify times. DO NOT ASSUME that since you have been scheduled at a certain time for a couple of weeks that you are automatically assigned that same time slot in future weeks.
3. Any changes in your health status, address, phone number, insurance or other pertinent information is your responsibility to report to office staff.
4. Appropriate attire for treatment is loose fitting clothing and lace up sneakers.

Patient or legal guardian signature required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient or legal guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for your cooperation!!

SORVA Staff