

**Orthopedic Physical Therapy of Northern Virginia, Ltd.**  
**Patient Information Form**

Date \_\_\_\_\_

Patient # \_\_\_\_\_

**(PLEASE PRINT)**

**PERSONAL INFORMATION:** STATUS: SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ IF STUDENT: F/T \_\_\_\_\_ P/T \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST M.I.

ADDRESS \_\_\_\_\_  
STREET APT # CITY STATE ZIP CODE

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ Do you wish to receive TEXT reminders? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes –what is your provider, Verizon, AT&T, Sprint : \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ Email reminders? YES \_\_\_\_\_ NO \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

EMPLOYER or SCHOOL: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET SUITE# CITY STATE ZIP CODE

IN CASE OF AN EMERGENCY CONTACT: \_\_\_\_\_

PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**INSURANCE:**

Subscriber's NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**Is condition due to an accident?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that I am responsible for any additional charges that would be incurred if my account has to be turned over for collection. I have read the HIPAA Privacy Notice provided. I will notify you of any changes in my health status or the above information.

**IT IS ALSO MY RESPONSIBILITY TO BE AWARE OF MY OWN INSURANCE COVERAGE, GUIDELINES, AND LIMITATIONS.**

**“I also authorize the release of information acquired in the course of my treatments to the physician and to qualified agencies.”**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PARENT (if minor)** \_\_\_\_\_ **DATE** \_\_\_\_\_

# OrthoPT NOVA, LLC

## CONSENT TO PHYSICAL THERAPY TREATMENT

Fascial Counterstrain Treatment Description and Patient Rights: Fascial Counterstrain (FCS) is a gentle, manual, treatment technique that identifies and alleviates fascial restrictions in the body. Utilizing light hands-on contact, anatomical structures are identified, slackened and held for 30-40 seconds in order to alleviate pain, reduce swelling, improve circulation, increase range of motion and restore pain free function. Depending on the structures targeted, contact may involve the cranium (head), chest wall (through breast tissue,) abdomen, pelvis, pelvic floor and/or buttocks. On some occasions patients report diffuse soreness, an increase in pain or a shifting of pain following treatment. I understand this is a normal result of treatment as swelling and inflammation are released from the body. I have the right to refuse FCS treatment to any area of the body. If I am uncomfortable with any aspect of treatment, I will advise my attending therapist in advance of my treatment so that the treatment session may be modified or so that I may be referred for alternative treatment. Refusal of treatment on a specific area will not terminate or affect my relationship with OrthoPT NOVA Physical Therapy.

General Consent: By signing below, I hereby consent to evaluation and treatment of my condition by my attending therapist (a physical therapist licensed in the State of Virginia. I understand the expected benefits, alternatives and possible risks of discomfort, which may result from any form of physical therapy, including FCS treatment. I acknowledge and understand that there is no guarantee that the proposed course of treatment will improve my condition. If any post treatment discomfort does not subside in 1-3 days, I agree to contact my attending therapist for the purpose of re-evaluation, medical referral or a change in plan of care. By signing below, I acknowledge that I have read and understand the above language of this "Consent to Physical Therapy Treatment" and that the benefits and risks of physical therapy (FCS) have been explained to me. Effective on the date below, and continuing until I revoke this document in writing, I hereby consent to Physical Therapy treatment including Fascial Counterstrain. I agree to update my medical status or condition, with any changes that may affect my treatment. If, at any time, I elect to modify or terminate treatment, I may do so by notifying my attending therapist.

PATIENT NAME \_\_\_\_\_

PATIENT RELATIONSHIP \_\_\_\_\_

AUTHORIZED SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



## Cancellation/Late Policy

As our practice continues to grow, we have updated our cancellation policy to better serve our patients. Your appointment time is reserved especially for you. Please call 703-354-1230 at least 24 hours before your scheduled appointment if you will be unable to keep your appointment. This allows OrthoPT NOVA to offer that appointment to another patient who needs care. **If you do not cancel your appointment at least 24 hours in advance, you will be charged \$75. This fee is not covered by insurance.**

Patients who cancel three **(3)** consecutive appointments will forfeit their remaining appointments. This allows OrthoPT NOVA to provide care to patients in immediate need.

### Late Arrival Policy

If you arrive **15** minutes past your scheduled time, we will cancel your appointment, and you will be charged **\$75**.

I have read and acknowledge the above policies.

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Patient Printed Name

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Patient or Responsible Party Signature

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Date