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

_____ Do you wish to receive TEXT reminders? YES ____ NO _____
CELL PHONE

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

_____ Email reminders? YES ____ NO _____
E-MAIL ADDRESS

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 _____

Orthopedic Physical Therapy of Northern Virginia

Cancellation Policy
Revised January 2022

Any appointment that is missed or canceled without more than 24 hours notice will be subject to a $40 cancellation fee. This policy is in place to ensure we are able to offer available appointments to our patients. Late cancellations make it difficult for us to provide appointment times to patients that wish to be seen.

Please sign that you have reviewed this policy. This document will be kept in your chart.

Thank You!

_____ _____

Patient or Responsible Party Signature Date