VICTORY
PHYSICAL THERAPY

108 Swedesboro Rd.
Suite 10
Mullica Hill, NJ 08062
Phone # (856) 223-8898
Fax # (856) 223-8799

Thank you for selecting Victory Physical Therapy for your hands-on healthcare needs. It was a pleasure speaking with you. Attached, you will find the new patient intake forms that you can print and complete before your appointment. You may have an additional form or two to complete and /or sign when you arrive.

Wear comfortable clothes and sneakers.

Should you have any questions, please do not hesitate to contact the office Monday through Friday between 8:30 am and 4:30 pm. Additionally, you will receive a reminder call a few days prior to your scheduled appointment. Kindly inform us that you have received and filled out the forms during the confirmation call. Be sure to bring the completed forms with you along with your script from your Dr and your insurance Card (s).

Thank you,

Staff at Victory Physical Therapy

Michael A. Walters, PT, CSCS
Kaitlyn V. Vaccarelli, PT DPT

VICTORY PHYSICAL THERAPY

Office Policy Regarding Insurance Assignment and Appointment Scheduling

Victory Physical Therapy will file insurance forms to assist you in every way we can. It must be fully understood that the contract is between you and your insurance company. You are fully responsible to know your insurance benefits and for any amount (deductible, co-ins and/or co-payment) that is not paid by your insurance.

1. I authorize my insurance benefits to be paid directly to Victory Physical Therapy.
2. I authorize the facility to release any medical records/billing to my physician.
3. I am financially accountable for the portion of my balance deemed patient responsibility by my insurance carrier/plan. My insurance has been explained to me. Benefits are subject to all terms and provisions of your plan. This is not a guarantee of payment. Please contact your insurance carrier with any questions.
4. Our office will **NOT** enter a dispute with your insurance company over your claim. This is your responsibility and obligation.
5. I agree to pay any collection and/or attorney fees that may arise because of any unpaid balance being forwarded to a collection agency and/or attorney to cause payment.
6. I will notify the office of any changes in my insurance policy.
7. All returned checks are subject to a $25 service fee.
8. **Appointments**- Please schedule appointments two weeks in advance with the front desk to ensure your preferred time is available.
9. Please give advance notice if not able to make a scheduled appointment.

Thank you for choosing Victory Physical Therapy!

I have read and understand the above policy and agree to its terms.

Patient Name: _____ Date: _____
(Please Print)

Patient/ Guardian Signature: _____

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Supplemental Informed Consent Form

Physical Therapy Treatment in the Era of Covid-19

Thank you for your continued trust in our practice. As with transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as the "Coronavirus" at any time or any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection and use of personal barriers, there is still a chance that you could be exposed to an illness in our office. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our office due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, therapist, staff, and sometimes other patients at all times.

Although exposure is unlikely; do you accept the risk and consent to treatment?

YES _____

NO _____

Patient Name: _____ Date: _____
(Please Print)

Patient/ Guardian Signature: _____

PATIENT INFORMATION:

Name: _____ Todays Date: _____

Occupation: _____ Date of Birth: _____

Referring Physician: _____ Physician Diagnosis: _____

PATIENT HISTORY:

Date of injury/onset of symptoms: _____ Surgery performed? Yes / No

Date of surgery (if applicable): _____ Type of surgery (if applicable): _____

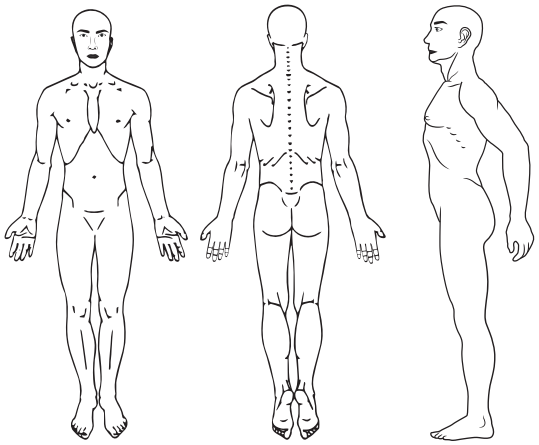
Cause of injury/symptoms: _____

Where did injury occur? (Home, work, sport, gym, etc.) _____

Chief complaint (Reason for today's visit): _____

Because of your injury, what are your biggest concerns? (Check all that apply):

__ Pain __ Muscle Weakness __ Difficulty Walking
__ Stiffness __ Fatigue __ Difficulty Reaching
__ Swelling __ Instability Other: _____



Present Symptoms:

- Location (Mark on body diagram)
- Location (mark on body
- Side of body (circle one): Right / Left / Both
- Description (check all that apply):

__ Pain __ Numbness
__ Weakness __ Tingling
__ Stiffness __ Burning
__ Swelling __ Ache
Other: _____

Frequency (check one):

__ Constant (always there 24 hrs.)
__ Intermittent (symptoms fluctuate based on position or activity)

Intensity (circle a # for each; 0 = none, 10 most severe, requiring hospitalization):

- Currently: 0 1 2 3 4 5 6 7 8 9 10
- Best: 0 1 2 3 4 5 6 7 8 9 10
- Worst: 0 1 2 3 4 5 6 7 8 9 10

Prior to your injury/onset, did you have any difficulty with the following? (check all that apply):

__ Dressing __ Walking __ Carrying Objects __ Driving
__ Showering __ Sitting __ Reaching __ Lifting Objects
__ Household Chores __ Standing __ Work / School __ Recreational Activities

What makes your symptoms worse? (Check all that apply):

__ Bending __ Down Steps __ Coughing / Sneezing
__ Turning __ Walking __ Sitting __ Standing __ Running __ Laying Down
__Up Steps __ Sports Other: _____

Complete Other Side

Do you experience disturbed sleep? Yes / No

Sleeping postures: __ Stomach __ Back __ R Side __ Left Side

What makes your symptoms better? (Check all that apply)

__ Bending __Walking __ Massage __ Sitting __ Lying Down

__ Medication __ Turning __ Standing __ Ice __ Heat Other: _____

What are your goals for physical therapy?

_____

_____

PAST MEDICAL HISTORY:

Other Medical Conditions:

_____

_____

Allergies (list all):

_____

_____

Past Orthopedic Injuries (sprains, strains, tendonitis, fractures, etc.):

_____

_____

Past Surgeries:

_____

_____

Previous history of falls? Yes / No

Medications (with dosage):

_____

_____

Patient Name: _____ Date: _____
(Please Print)

Patient/ Guardian Signature: _____