BAYVIEW PHYSICAL THERAPY
& WELLNESS CENTER
A personal touch to healthy living

7930-F Chesapeake Blvd.
Norfolk, Virginia 23518
phone: (757) 588-4325
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Patient Registration and Authorization to Treat

Patient Information (Please Print)

Name ______________________________ How shall we address you? ______________

Address: ______________________________ Apt: ________ SS#: ______________

City ____________________ State: ______ Zip code: ____________ Birth Date: _____/_____/_______

Cell #: __________________ Email: ______________________________ Sex: ☐ F ☐ M

Home# __________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Work#: ____________________ X________ Occuaption; ______________________________

Emergency Contact: ______________________ Phone: ________________ Relation: __________

Responsible Party (if other than patient)

Name/Co. ______________________ Contact: ______________ SS# ________________

Address ____ Phone ________________

Authorization to Treat:
I hereby authorize Bayview Physical Therapy & Wellness Center to provide treatment as ordered by my physician if necessary.

Assignment of Benefits: (If Applicable)
I hereby authorize payment directly to Bayview Physical Therapy & Wellness Center of the insurance benefits due to me for the treatment provided.

Financial Responsibility: (If Applicable)
I understand that I am financially responsible for all services provided in accordance with this Financial Policy Agreement. In the event my insurance company denies payment, I understand that I am responsible for payment to Bayview Physical Therapy & Wellness Center.

Cancellation Policy: patient initials_________
I understand that **24 hours cancellation notice** is required. Bayview Physical Therapy reserves the right to charge a **$25.00 fee, which is not covered by insurance**, for same-day cancellations and no shows.

Collection Policy:
Patient accounts remaining inactive for more than **thirty (30) days** will be considered delinquent. Bayview Physical Therapy reserves the right to forward delinquent accounts to collections. I hereby acknowledge that signing this agreement notifies me that my credit report may be accessed through the local credit bureau. Furthermore, I hereby agree that should my account be deemed "delinquent", all attorney's fees, court costs, and/or collection fees incurred by Bayview Physical Therapy & Wellness Center will be reimbursed to Bayview Physical Therapy & Wellness Center.

______________________ ______________________ ______________
Patient name (print) Signature Relationship

______________________ ______________
Witness Date

Revised 6.17.20.dc

Past Medical History Questionaire

Patient Name:____________________________ DOB:________________ Date:________________

Please describe the history and onset of the present condition, include dates:____________________

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____

Date and type of Surgery (if applicable):____

What are your chief complaints due to your condition? Please check all that apply.

_ Awakened by pain	_ Headaches	_ Pain worse with activity
_ Burning	_ Irritability	_ Spasm
_ Difficulty falling asleep	_ Loss of function	_ Swelling
_ Difficulty finding comfortable sleeping pos.	_ Loss of motion/stiffness	_ Tingling
_ Difficulty walking	_ Nausea	_ Weakness
_ Dizziness	_ Numbness	_ Other ______________
_ Fatigue	_ Pain Worse?: _ am _ pm	_ Other ______________

If you have pain, please rate your pain today on a scale of 0 to 10? (0 = no pain, 10 = worse possible): _____/10

Where is your pain located and how would you describe it?____________________________________

____

Rate your symptom intensity in the past 5 days: Lowest: ____/10 Highest: _____/10

Please list any contraindications to treatment or precautions that we should know: ________________

____

Please list any hospitalizations and/or surgeries (use extra sheet if needed)

Type of Surgery	Date	Results

Please list any diagnostic tests and results related to your current condition

Test ____________________ Date ____________________ Results ____________________

____

____

Please list other specialists seen for your current condition other than prescribing physician

Name ______________ Specialty ______________ Reason ______________ Last Seen ______________

____

____

Height:_____ Weight:_____ Please mark all conditions that you have a history of:

_Allergies	_ Dizziness	_ Hx of Smoking	_ Metal Implants	_ Pacemaker
_Anxiety	_ Epilepsy	_ High BP	_ Nausea/Vomiting	_ Pregnancy (current)
_Asthma	_ Fainting	_ Joint Replace	_ Neurological	_ Rheumatoid Arthritis
_Bowel Dys.	_ Headaches	_ Fatigue	_ Osteoarthritis	_ Shortness of Breath
_Cancer	_ Heart Cond.	_ Mental/Cognitive	_ Osteoporosis	_ Stroke/CVA

_ diabetes __other____

Do you currently smoke? __yes __no

Please list all medications and supplement you presently take (add sheet if needed)

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____

____

____

Have you fallen in the past 12 months? __no _yes how many times?__ injured? _no _yes

Have you recently been hospitalized? __ no __yes: when were you discharged? ________

Have you received therapy in the past 12 months? __ yes __ no If yes, how many visits? ____

With whom do you live? _spouse _parent(s) _ children _ alone _ other_________

In what type of home do you live? _single level _ 2 level __ 1st fl apt _ upper level apt. other______

If multi-level dwelling do stairs have handrails? _ no? __yes: 1 or 2 (circle)

Are there stairs to entrance? _no _ yes how many?__ handrail? _no _ yes 1 or 2 (circle)

Bathroom located? _ 1st level _ 2nd + level your bedroom located? _ 1st level __2nd + level

What do you hope to achieve with physical therapy?________________________________

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