Loudoun Sports Therapy Center

"Don't let pain limit you. We Care. We Listen. We Get RESULTS!"

Patient's Full Name (1st, middle, last) _____ DOB _____

CELL Phone _____ HOME/WORK phone _____

Address _____

Email _____ Marital Status ☐ single ☐ married ☐ divorced ☐ widowed

Please present your driver's license and insurance card for verification purposes. (This is required by law.)

What problem/condition/injury will we be seeing you for? _____

Which physician referred you for this round of physical therapy? _____

Physician Phone # _____ Office Location _____

Is your injury due to a Motor Vehicle Accident Fall outside the home Work Injury

Have you seen or will you be seeing a lawyer for the above listed problem or condition? Yes No

Have you seen any of the following since your last round of physical therapy? Please check all that apply.

☐ Chiropractor ☐ Osteopath ☐ Occupational Therapist ☐ Speech Therapist ☐ Physical Therapist ☐ Homecare

Are there any other new medical conditions that we need to be made aware of? _____

Primary Insurance Company _____ Policy Holder's Name _____

Your relationship to policy holder _____ Policy Holder's Date of Birth _____

Social Security Number _____ Policy Holder's Employer Name _____

Policy Holder Employer's address _____

By signing below, I am indicating that:

1. I have been a patient of Loudoun Sports Therapy Center within 2 years and have previously read and signed the patient intake forms.
2. I give the staff of Loudoun Sports Therapy Center consent for treatment for the above listed problem or condition.
3. I have read and understand the financial policy as indicated in the patient intake forms. (If you need a copy, 1 is available.)
4. I have fully read the cancelation/no-show policy and understand that I am responsible for calling the office with 24 hours advance notice to cancel or reschedule an appointment or I am responsible for fees incurred. All no-shows and cancelations less than 24 hours notice incur a $50 fee.
5. I have read the HIPPA privacy form and acknowledge previous receipt. I give permission for the following person(s) to have access to my medical information: _____
6. I hereby authorize Loudoun Sports Therapy Center to bill my insurance company for all services rendered and accept payment from them on my behalf.
7. I understand that any charges that are indicated as my responsibility by my insurance company will be my responsibility and will be due at the time service is provided. While LSTC staff do their best to collect the correct amount up front I understand that I may receive a statement claims are processed and understand that it will be my responsibility.

_____ _____

Patient Signature (parent or guardian if patient under 18) Date

_____ _____

Printed Name Staff Witness

This form is for patients who have been seen previously at LSTC within the last 2 years.

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NO-SHOW - CANCELLATION POLICY

At Loudoun Sports Therapy Center, it is our goal to help you get the most out of your physical therapy visits. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you meet your goals. A recently published study found that patients who attend all of their physical therapy visits are 93% more likely to recover from injury whereas those that miss even one visit have a lower potential for recovery. It is extremely important that you attend your scheduled appointments.

Our schedule is very full and certain time slots are not always available for patients who need them. If you need to cancel or change a scheduled appointment, for any reason, we require a day's notice of the cancellation. When you call we will assist you in rescheduling this appointment because helping you recover is very important to our team.

Please read our policy and sign at the bottom indicating you understand our same-day cancellation / no-show policy.

1. As experts, we know that **you will not get better if you do not attend your appointments**. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
2. While we understand that illness can strike at anytime, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for late notice. If you are ill, providing at least a days' notice will allow us to help someone else and will help you avoid our missed visit fee.
3. For all appointments, we expect that you will arrive on time, dressed for your session, and ready to begin at your scheduled treatment time.
4. While traffic can be unpredictable, we need you to call us immediately if you're running late for your scheduled appointment, so we can be prepared for your late arrival.
5. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
6. Please note: when you need to change or cancel an appointment, we need 24 hours' notice so we have enough time to help someone else who needs that appointment time. Same-day cancellations or no-shows are not permitted and there is a **$50 missed visit fee if you do not provide at least a days' notice of your appointment change or cancellation. This is your responsibility as insurance will not cover it.** To avoid our missed visit fee, call our office during business hours - at least a day in advance for any appointment changes or cancellations. This will allow us to reschedule you for another time and help other patients get the care they need by offering that appointment time.

Thank you for reviewing this policy. Please sign and return the signed copy and keep the second copy for your records.

We look forward to working with you to meet your physical therapy goals.

Michael Bills, Owner
Loudoun Sports Therapy Center

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

Patient Signature _____ Patient Name _____ Date _____

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PATIENT COPY

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