Health History

Patient Name _____ Date of Report _____

Diagnosis _____ Physician _____

MEDICAL HISTORY:		NO	YES
1.	Have you had a heart attack?	☐	☐
2.	Have you had heart surgery?	☐	☐
3.	Do you have heart disease?	☐	☐
4.	Have you been told by an M.D. you have angina/palpitations?	☐	☐
5.	Have you had a stroke?	☐	☐
6.	Is your blood pressure over 180/104?	☐	☐
7.	Are you pregnant?	☐	☐

ANY "YES" RESPONSES REQUIRE CONSULTATION WITH, AND FURTHER CLEARANCE BY, THE PRESCRIBING PHYSICIAN BEFORE TESTING MAY CONTINUE!

Clearance Granted? ☐ NO ☐ YES By: _____

Date obtained clearance: _____

_____

(Check only positive responses)

(a) ☐ Asthma
(b) ☐ Hernia
(c) ☐ Allergies
(d) ☐ Epilepsy/Seizure
(e) ☐ FX/Dislocations
(f) ☐ Surgery
(g) ☐ Prosthesis/Brace
(h) ☐ Drug/Alcohol abuse
(i) ☐ Diabetes
(j) ☐ Incontinence

Explanation of all positive responses and other conditions not listed:

_____

_____

_____

_____

_____

_____

Present medications: _____

_____

_____

_____

Initial B/P Time: _____ B/P _____ Pulse _____

Ending B/P Time: _____ B/P _____ Pulse _____

VENTURE PHYSICAL THERAPY _____
VENTURE HAND THERAPY _____

PLEASE GIVE THE RECEPTIONIST A COPY OF YOUR DRIVER'S LICENSE AND INSURANCE ID CARD

Thank You

PATIENT INFORMATION SHEET

Today's Date _____ How did you hear about us? _____

Patient's Name _____ Date of Birth ____/____/____
First Middle Last Month Day Year

Street Address: (No P.O. Box Please) _____
Street

_____
City State Zip

Social Security Number _____ Home Phone # (____) _____
Area Code

Marital Status M, S, W, D Age _____ Sex M F
Please Circle One Please Circle One

In case of emergency, please contact: _____ Ph # _____ Relationship _____

Employer/School _____ Occupation/Position _____

Employer's Address _____ Work # _____

Parent or Guardian name (if patient is a minor) _____

Address _____

Father's Employer _____ Work # _____

Mother's Employer _____ Work # _____

Spouse Name _____ DOB _____

Spouse's Employer _____ Work # _____

Position/Occupation _____ SS# _____

Please describe your injury or area of pain for which you are being seen today _____

_____

Was your injury due to an accident? Yes No If yes, was it job related? _____ Was your injury due to an automobile accident? _____

Please explain how your injury occurred. _____

_____ Date of injury? ____/____/____
Month Day Year

Auto Insurance Information on the vehicle you were in: Carrier _____ Policy Number _____

Adjuster _____ Claim # _____ Phone # _____

Insurance Information

Do you have Medicare Coverage? _____ ID# _____

If yes, are there any primary payers other than Medicare? _____

If yes, please give information _____

Are you currently employed? _____ Full Time or Part Time

Primary Carrier _____ ID# _____

Group # _____ Phone # _____

I certify that the above information that I have given is accurate and true to the best of my knowledge. _____
PLEASE INITIAL

CONSENT TO TREAT

I hereby voluntarily consent to receive treatment for my condition according to my treatment plan. I have been informed by my therapist of the treatment procedures to be utilized, including information about significant risks, benefits of and alternatives to the procedures and have had my questions answered. I understand this (these) treatment(s) will be performed by an appropriately credentialed staff member employed by or acting as an agent of Venture Healthcare. I further understand that I may rescind this consent at any time and will be informed of the potential consequences of that decision.

Patient/Legal Guardian _____

Witness _____ Date _____

DO NOT WRITE IN THIS BOX

Account # _____

Referring Physician _____

ICO9 code _____

Medicare Trauma Code _____

Medicare Occurrence Date _____

Verified Initials

Administrative Office:
240 Corporate Center Drive
Stockbridge, GA 30281
770-389-9006
770-389-7388 fax

Venture Physical Therapy Clinics:
Atlanta
615 Peachtree Street
Suite 1000
Atlanta, GA 30308
404-607-0309
404-607-0906 fax

Fayetteville
1275 Highway 54 West, Suite 101
Fayetteville, GA 30214
770-716-0303
770-716-0690 fax

Marietta
631 Campbell Hill St., Suite 200
Marietta, GA 30060
770-424-6787
770-426-7925 fax

Norcross-Doraville
6285 Jimmy Carter Blvd., Suite 1100
Norcross, GA 30071
770-409-1235
770-409-9986 fax

Northside
5445 Meridian Mark Rd., Suite 395
Atlanta, GA 30342
404-256-5655
404-256-1720 fax

Stockbridge
125 Medical Blvd.
Stockbridge, GA 30281
770-474-9514
770-389-5602 fax

West Cobb
5041 Dallas Hwy., Suite C
Powder Springs, GA 30127
770-425-2151
770-425-5982 fax

West Paces
3200 Downwood Circle, Suite 520
Atlanta, GA 30327
404-352-5700
404-352-5730 fax

Venture Hand Therapy Clinics:
East Cobb
1000 Johnson Ferry Rd.
Bldg. D, Suite 135
Marietta, GA 30068
770-977-1744
770-977-6934 fax

Fayetteville
1275 Highway 54 West, Suite 101
Fayetteville, GA 30214
770-716-0303
770-716-0690 fax

Marietta
140 Lucy St., Suite F
Marietta, GA 30060
770-792-8880
770-792-8883 fax

Northside
5445 Meridian Mark Rd., Suite 395
Atlanta, GA 30342
404-256-5655
404-256-1720 fax

Stockbridge
125 Medical Blvd.
Stockbridge, GA 30281
770-474-9514
770-389-5602 fax

West Cobb
5041 Dallas Hwy., Suite C
Powder Springs, GA 30127
770-425-2151
770-425-5982 fax

Venture On/Site Rehab
3200 Downwood Circle, Suite 520
Atlanta, GA 30327
404-846-0999
404-352-5730 fax

PATIENT FINANCIAL ACCEPTANCE AGREEMENT FOR SUPPLIES

I understand that each insurance policy has different benefits for supplies. Some policies may cover supplies, while other policies do not. I further understand that should my insurance carrier deem all or part of the charge for supplies issued during the course of my treatment non covered, I am responsible for payment and will arrange for such a payment with the Administrative/Billing department upon notification.

Patient Signature/Guardian

Date/Clinic/Location

Account Number

VENTURE PHYSICAL THERAPY

Payment Policy

Physical Therapy / Hand Therapy

Affiliated Clinics:

☐ **MARIETTA**
PT/OT/Hand
631 Campbell Hill St.
Suite 200
Marietta, GA 30060
770-424-6787
770-426-7925 fax

☐ **STOCKBRIDGE**
PT/OT/Hand
125 Medical Blvd.
Stockbridge, GA 30281
770-474-9514
770-389-5602 fax

☐ **WEST COBB**
PT/OT/Hand
5041 Dallas Hwy.
Building 1, Suite C
Powder Springs, GA 30127
770-425-2151
770-425-5982 fax

We make every effort to verify coverage with your insurance company. In the event your insurance company deems all or part of our charges non-payable, you will be responsible for those charges. To avoid misunderstandings, our Business manager invites early discussion of financial problems or questions regarding fees for payment from insurance carriers. You will be responsible for the percentage of the charges that insurance will not cover at the time that services are rendered. If you have more than one insurance policy that will pay for your charges here at our clinic then the following policies will apply:

1. A Venture Healthcare Clinic can bill only one insurance company at a time. If your primary insurance is "automobile" it must be filed first. Upon notification that your PIP coverage is exhausted, private insurance will then be filed for all past and future charges.
2. We cannot accept the responsibility of negotiating claims with insurance companies or other persons. The patient is responsible for payment of his/her medical care within a reasonable time, regardless of the status of a claim.
3. We encourage you to refer to your insurance policy for details, including limitations, regarding your coverage for out patient physical therapy, since we cannot guarantee payment of your claims.
4. Reduction or rejection of your claim by your insurance company, does not relieve the financial obligation you have incurred.
5. We require a signature below on workers compensation claims in the event that the entire claim is controverted. This bill would then be the patient's responsibility.
6. If you prefer to file your own insurance, fees will be payable at the time services are rendered.

*** There will be a $20.00 charge for no show appointments or any cancellations not made 24 hours in advance of appointment time.***

In an effort to keep the rising costs of quality medical care down, it is very important to receive timely payment for services rendered. If collection and/or legal services are required to obtain payment, I agree to pay all costs reasonably incurred including attorney fees, court costs and interest at a rate of 1 1/2 % per month.

I understand that I am responsible for payment of services. I further understand that insurance may be filed by your office as a courtesy, and does not constitute a contract between therapist and insurance company for payment of your services. I have read the payment policies as explained on this form and understand my responsibilities.

Patient or authorized person (signature) Date

I authorize the release of any medical information necessary to process the attached claim for services rendered. I further authorize payment of medical benefits directly to the therapist. Photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient or authorized person (signature) Date