



# Comber Physical Therapy, LLC

Mooretown Road Office: 101-B Bulifants Blvd. Williamsburg, VA 23188

Phone: (757) 229-9740 Fax: (757) 229-9741

Newtown Office: 5388 Discovery Park Blvd, Suite 100, Williamsburg, VA 23188

Phone: (757) 903-4230 Fax: (757) 903-4231

## RESPONSIBLE PARTY INFORMATION AND AGREEMENT

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Patient's SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Permanent Address: \_\_\_\_\_

Home Ph#: ( ) \_\_\_\_\_ / Cell Ph#: ( ) \_\_\_\_\_ / Email Address: \_\_\_\_\_

Marital Status: Single / Married

Employment Status: Part-time / Full-time / Student / Retired

Emergency Contact Name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Referring Physician: \_\_\_\_\_

### Employer Information

Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_ Wk #: ( ) \_\_\_\_\_

### Spouse's Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Ph#: ( ) \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### If Patient is a child under the age of 18:

Father's Name: \_\_\_\_\_ / SS#: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ / SS#: \_\_\_\_\_

Comber Physical Therapy, LLC will file insurance claims as a courtesy to the patient. The financial responsibility for services rendered rests solely with the patient/guarantor. Verification of your insurance coverage is not a guarantee of benefits. Benefits and extent of coverage will be determined by your insurance carrier at the time a claim is submitted and acknowledged. It is the patient/guarantor's responsibility to pay for any non-covered services, deductibles, co-payments or any other balance not paid by the insurance company for professional services rendered to me, my spouse or child by Comber Physical Therapy, LLC. I also understand that should the account become delinquent, I shall be charged 18% interest per annum (ie. 1.5% per month) on the balance due and owing until it is paid in full. I hereby waive all homestead exemption rights and I shall also be responsible for all costs of collection including 33 1/3% attorney fees. Default begins as of 30 days from last payment.

**\*I understand that I will be billed and responsible for paying a fee of \$25.00 for missed appointments and those appointments cancelled without a 24 hour notice\* Initials: \_\_\_\_\_**

I hereby authorize treatment by Comber Physical Therapy, LLC and authorize the release of records to any agency involved in the payment of treatment for the patient named below.

If patient is under 18 years of age, the signature of a parent or guardian is required.

Signed by \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relation to Patient if under 18 \_\_\_\_\_

**Comber Physical Therapy, LLC**

101 Bulifants Blvd, Suite B  
Williamsburg, VA 23188

5388 Discovery Park Blvd, Suite 100  
Williamsburg, VA 23188

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ / DOB: \_\_\_\_\_

I have received **HIPAA** information and understand the information that is given to me.

Signed \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ I refuse to sign the information for HIPAA.

\*Can information pertaining to your treatment at Comber Physical Therapy, LLC be released to your spouse, or any other individual? If yes, please list below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Do we have permission to send information regarding your treatment to your primary/family physician?

Yes       No

Primary/Family Physician's Name: \_\_\_\_\_

\*Can detailed information about your appointments or treatment at Comber Physical Therapy, LLC be left with a family member or on your answering machine at home?  
(Please circle one and initial.)

Yes \_\_\_\_\_ / NO \_\_\_\_\_

**How did you hear about us? (Please check all that apply)**

- Previous Patient
- Friend or Family
- Physician Recommendation
- Advertisement
- Website
- Other: \_\_\_\_\_

# MEDICAL SCREENING FORM

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_ / DOB: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

**What is your chief complaint today?**

## Please circle YES or NO

**Have you or any immediate family member ever been told you have:.....**

	<u>SELF</u>	<u>FAMILY</u>
Diabetes ?.....	Yes...No	Yes...No
High blood pressure ?.....	Yes...No	Yes...No
Heart disease ?.....	Yes...No	Yes...No
Angina/ chest pain ?.....	Yes...No	Yes...No
Stroke ?.....	Yes...No	Yes...No
Osteoporosis ?.....	Yes...No	Yes...No
Rheumatoid arthritis ?.....	Yes...No	Yes...No
Cancer ?.....	Yes...No	Yes...No

**In the past 3 months have you had or do you experience:**

Nausea/ vomiting ?.....	Yes...No
Fever/ chills/ sweats ?.....	Yes...No
Unexplained weight change ?.....	Yes...No
Numbness or tingling ?.....	Yes...No
Changes in appetite ?.....	Yes...No
Difficulty swallowing ?.....	Yes...No
Changes in bowel or bladder function ?....	Yes...No
Shortness of breath ?.....	Yes...No
Dizziness ?.....	Yes...No
Upper respiratory infection ?.....	Yes...No
Urinary tract infection ?.....	Yes...No
A change in your health ?.....	Yes...No

Date of last physical exam: \_\_\_\_\_

Medications currently being taken:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries & Dates: \_\_\_\_\_

\_\_\_\_\_

**Is physical therapy the result of an injury?**

Please circle: **YES** or **NO**

If **YES**, date of injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If **YES**, type of injury: WORK / AUTO / OTHER

## Please circle YES or NO

**Do you have a history of:**

Headaches ?.....	Yes...No
Bronchitis ?.....	Yes...No
Kidney disease ?.....	Yes...No
Rheumatic fever ?.....	Yes...No
Ulcers ?.....	Yes...No
Sexually transmitted disease?..	Yes...No
Incontinence (urinary or fecal)?.	Yes...No
Seizure?.....	Yes...No
Allergies/ Asthma ?.....	Yes...No

**Are you currently:**

Depressed ?.....	Yes...No
Under stress ?.....	Yes...No
Pregnant ?.....	Yes...No

**Please circle the following:**

Are your symptoms:

getting worse / the same / improving

How do you sleep at night?

fine / moderate difficulty / only with medication

Do you have problems with:

(circle all that apply)

Hearing / vision / speech / communication

Do you drink alcoholic beverages?

**YES**      **NO**

If **YES**, how many drinks do you routinely have per week? \_\_\_\_\_ / week

Do you or have you in the past smoke tobacco?

**YES**      **NO**

If **YES**, \_\_\_\_\_ packs/ day for \_\_\_\_\_ years

Last tobacco use: \_\_\_\_\_



## Comber Physical Therapy, L.L.C.

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"Helping you back to a Healthy Life"

**Please use the diagram below to indicate where you feel symptoms right now.**

**Use the following key to indicate the different types of symptoms:**

### KEY

<b><i>Pins &amp; Needles = 00000</i></b>	<b><i>Stabbing = /////</i></b>
<b><i>Deep Ache = ZZZZ</i></b>	<b><i>Burning = XXXX</i></b>

