MVA -MOTOR VEHICLE

PROGRESS PHYSICAL THERAPY REFERRAL

Center Number _______ Center Name ________________
Account / Reg# ____________ Date Taken ___________ Taken By ____________
Appointment Date ______________ Time ____________ Transportation (*Circle One*) Y N
Therapy [*Circle One*] PT OT Work Harding FCE Job Analysis

PATIENT INFORMATION [Initial intake by Center]

*****First Name*** ______________ MI ___ *****Last Name*** ____________________

*****Date of Birth*** ___________ Gender [Circle One] M F SS# _____-____-_______

*****Mailing Address*** *****[Street]*** ______________________________

*****[City]*** ___________________ *****[State]*** _____ *****[Zip Code]*** _______

Physical Address [Street] ______________________________

☐ same [City] ____________________ [State] ______ [Zip Code] ________

*****Home Phone*** (____) - _____-__________ *****Work Phone*** (____) - _____-__________

*****Cell Phone*** (____) - _____-__________

*****Injured Area of Body*** ____________________ *****Date of Injury*** ______________

*****MVA Insurance Co.*** ___________________ *****Claim #*** ____________________

MVA Billing [Street-P.O. Box]______________ City __________ State _____ Zip ________

***** MVA Ins. Co. Phone #***(_____) -______ - __________ Adjuster Name _______________

Personal Health Ins. Company ______________________ Effective Date __________
Billing Address _____________________ City ____________ State _____ Zip________
Insured / Relationship __________________________ DOB-[subscriber]__________
Ins. ID# __________________________ Group# _______________ CO-PAY $ _______
Phone # (____) - ____ - _________
Primary Physician ____________________ Phone (_____) - _______ - ___________
Benefits ____

*****Attorney Name*** ________________________ Phone (_____) - _______ - __________

*****Referring Physician*** ____________________ Phone (_____) - _______ - __________

How did you hear about our company? (*Circle One*)
Doctor Lawyer Friend / Family Employer Phone Book Ad
Other ______________________________________

My signature below states that you I reviewed the information above and the information is true and correct .My injury is a result of a "Motor Vehicle" incident.

Patient Signature ____________________________ Date ________________

*Our Goal is for you to have a **DYNAMIC** experience—Thank You for choosing Progress Physical Therapy*

PROGRESS PT
CENTERS FOR FITNESS AND REHABILITATION

DATE: ______________

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please check if you have had problems with or are presently complaining of any of the following:

_____High blood pressure
_____Diabetes
_____Cancer
_____Heart Disease
_____Chest pain / Chest tightness
_____Shortness of breath
_____Dizziness
_____Vision Problems
_____Chronic Fatigue
_____Swollen ankles
_____Palpitations
_____Light-headedness
_____Frequent urination
_____Rheumatic fever

_____Asthma
_____Bronchitis
_____Pneumonia
_____Persistent Cough
_____T.B.
_____Hay fever
_____Abdominal discomfort
_____Nausea
_____Vomiting
_____Blood in stool
_____Ulcers
_____Amputation
_____Loss of use of body region
_____Change in bowel habits

_____Unexplained weight gain/loss
_____Hepatitis or jaundice
_____Headache
_____Difficulty urinating
_____Arthritis
_____Low back problems
_____Alcohol abuse
_____Drug abuse
_____Gout
_____HIV
_____Balance Deficits
_____Osteoporosis
_____Seizure Disorder
_____Other

PAST SURGICAL HISTORY

Please list all surgeries, include date, you have had, related or unrelated to current problem

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

CURRENT MEDICATIONS Please list all current medications, related or unrelated to current problem. Write down next to the medication what it is for.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

PROGRESS PT

CENTERS FOR FITNESS AND REHABILITATION

DATE: ______________

PLEASE DESCRIBE IN DETAIL THE ACCOUNT OF YOUR INJURY:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

WHAT HAPPENED IMMEDIATELY FOLLOWING THE INJURY?

1.) Where did pain occur? ______________________________

2.) Did you lose consciousness? ___ yes ___ no ___ unsure

3.) Type of emergency care provided: __ none __ bandaging __ bracing __ CPR__ neck collar__ splinting

4.) Immediate destination after accident: ___ work ___ home ___ school ___ hospital ___ MD's office

5.) Who drove you: ___ yourself ___ a friend ___ an ambulance ___ a family member

6.) Date of hospital/Doctor visit: ___/___/___ Name of hospital / examining MD:______________

7.) Were you admitted to the hospital? ___ yes ___ no (If yes, date of discharge: ___/___/___)

8.) Did you have an X-ray? ___ yes ___ no (If yes, of what?______________________)

Where was it taken?______________ When was it taken? ___/___/___

9.) Did you have an MRI? ___ yes ___ no (If yes, of what?______________________)

Where was it taken?______________ When was it taken? ___/___/___

10.) If you answered yes to having an MRI or X-ray, what were the results?

____

283 Second St. Pike, Suite 145, Southampton, PA 18966

215-494-2255 / fax: 215-494-2258

PATIENT NAME: ______________________

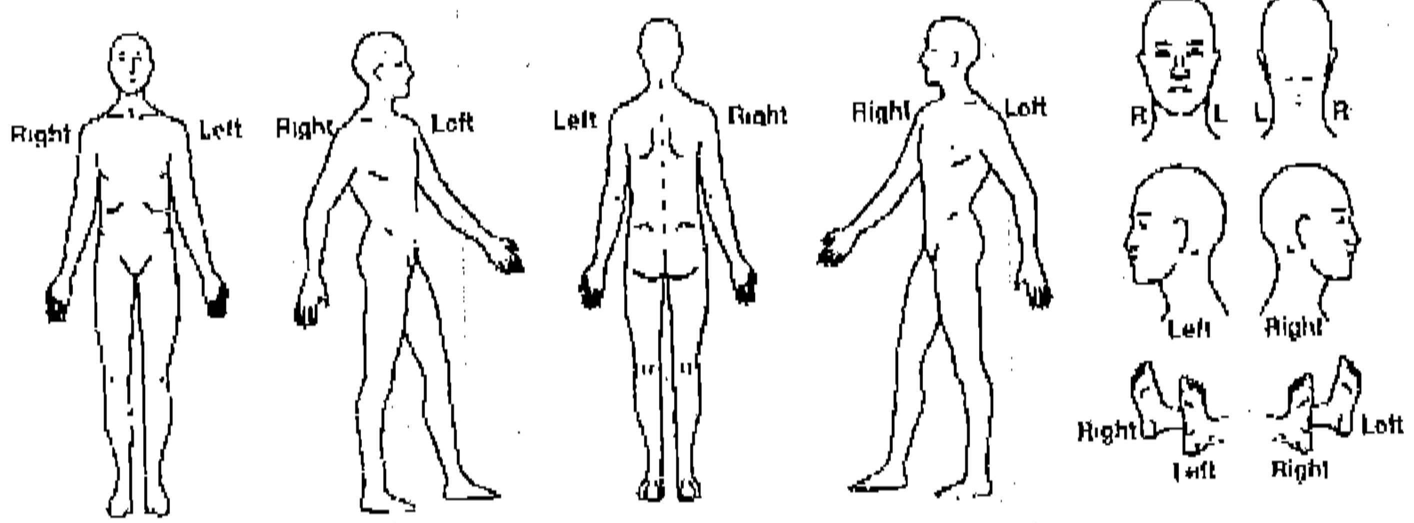
PROGRESS PT

CENTERS FOR FITNESS AND REHABILITATION

DATE: ________________

PRESENT COMPLAINTS

- **Circle the region(s) where you are experiencing pain or a problem right now.**
- **Place a number in each circle from the pain scale below.**



_____ Your pain at it's BEST

_____ Your pain at it's WORST

0 – No pain at all
1 – Very mild
2 – Mild
3 – Bothersome
4 – Moderate
5 – Able to complete daily routine
6 – Unable to complete daily routine
7 – Unable to do anything, but rest
8 – Considering going to the hospital
9 – Going to the hospital
10 – Calling 911, excruciating

I authorize payment of medial benefits to PROGRESS PT Centers for Fitness and Rehabilitation for all care provided by the aforementioned facility or its employees.

Authorized person's signature ______________________________

I authorize the release of any medical or other information necessary to process all medical claims. I also request payment of government benefits either to myself or to PROGRESS PT Centers for Fitness and Rehabilitation.

Authorized person's signature ______________________________

PATIENT NAME: ______________________________

PROGRESS PT

CENTERS FOR FITNESS AND REHABILITATION

I, ______________________________, understand that I am solely
Patient Name
responsible for payment of all bills for services rendered for all treatment provided by Progress PT for injuries sustained on

____________________.
Date of Accident

Regardless of the outcome of settlement of my case, Progress PT can hold me solely responsible for all charges.

My signature below is proof of agreement to the above statement.

Signature: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________

PROGRESS PT
CENTERS FOR FITNESS AND REHABILITATION

MVA Insurance Information Release Form

I authorize the release of first party medical benefits information regarding this automobile accident, including PIP limits and amount of remaining funds to cover my medical expenses.

Signature:____________________ Date:____/____/____

Witness Signature:____________________ Date:____/____/____

1331 East Wyoming Ave., Suite 4120 Philadelphia, PA 19124 215-831-1170 / fax: 215-744-7394

PROGRESS PT

CENTERS FOR FITNESS AND REHABILITATION

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Patient Name:____________________ Date of Birth:____/____/____

Address:____

City/State:____________________ Zip:____________________

Phone:____________________ SSI #:____________________

This is a formal request to have the aforementioned patient's records released from:

____

____

____

The records we are requesting to be released are:

____

____

These records are to be forwarded to:

Progress PT Centers for Fitness and Rehabilitation
283 Second Street Pike, Ste. 145
Southampton, PA 18966
Phone:(215)-494-2255 / fax: (215)-494-2258

Patient Signature:________________________ Date:____/____/____

This authorization will be valid for six months from date of signing. The request may be revoked by the aforementioned patient or legal guardian by written request only.