OPTIMUM WELLNESS CENTERS POWERED BY ReEnvision PT
Redefining Access to Quality Care

New Patient Intake Paperwork

Patient Information						
First Name		Last Name			Date of Birth	
Address			City	State	Zip Code	
Phone Number		Email			Gender Male ◯ Female ◯	
Occupation			Was this injury a result of work? Yes ◯ No ◯			
Height	Weight	Smoke Yes ◯ No ◯	Drink Yes ◯ No ◯		Pregnant Yes ◯ No ◯	

Emergency Contact		
Full Name	Relationship	Phone Number
Full Name	Relationship	Phone Number

Health and Medical Information		
Referring Physician	Diagnosis	Images Performed
Are you under the care of another provider for this diagnosis? Yes ◯ No ◯	Previous Treatment	
What is your regular exercise routine?	How would you rate your current health? Excellent Good Fair Poor	
Current medications:		

Past Medical History
(Please circle what applies)

Cancer	High Blood Pressure	Heart Disease	Angina/Chest Pain
Heart Attack	Pacemaker	Asthma	Shortness of Breath
Diabetes	Osteoporosis	Osteoarthritis	Rheumatoid Arthritis
Stroke	Dizziness/Light-Headed	Falls	Nausea/Vomiting
Chronic Fatigue	Swelling in the Legs	History of DVT	Weight Loss/Gain
Fevers	Numbness/Tingling	Changes in Bowels	Changes in Bladder
Night Sweats	Thyroid Problems	Headaches	Concussions
Fractures	Metal Implants	Kidney Disease	Liver Disease
HIV/AIDS	Fibromyalgia	Hepatitis	Sexually Transmitted Disease
Ulcers	Tuberculosis	Lung Disease	Allergies

Have you had a recent illness? (If yes, please explain)

In the past month, have you often been bothered by feeling down, depressed, or hopeless?

Yes ◯ No ◯

During the past month, have you been bothered by little interest or pleasure in doing things?

Yes ◯ No ◯

Do you take blood thinners?	Are you allergic to latex?
Yes ◯ No ◯	Yes ◯ No ◯

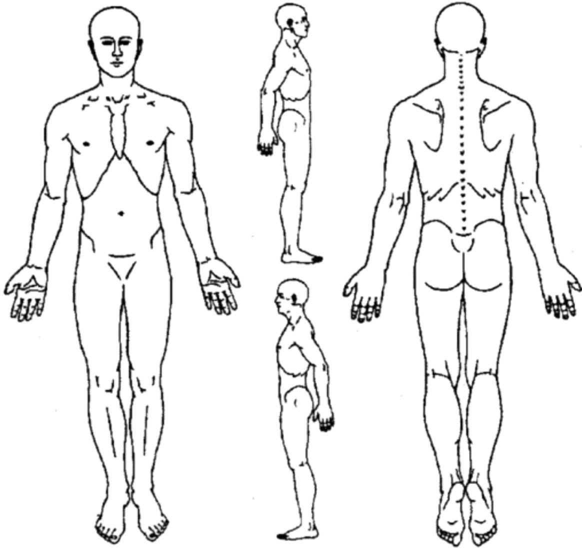
Insurance Information

Insurance Carrier	Policy Number
Policy Holder’s Name	Policy Holder’s Date of Birth

Last Updated: 2/6/2025

Visit Information											
Please answer the following questions based on how you have felt in the past 2 weeks. (Pain Scale: 0= No Pain 10= Worst Imaginable)											
Best-	0	1	2	3	4	5	6	7	8	9	10
Current-	0	1	2	3	4	5	6	7	8	9	10
Worst-	0	1	2	3	4	5	6	7	8	9	10
How would you rate your overall function?											
	0	1	2	3	4	5	6	7	8	9	10

Pain Body Diagram	
Please use these symptoms to mark your pain: Dull Ache- ZZ Sharp/Stabbing- //	 Pins/Needles- 00 Burning- XX
What makes your symptoms worse?	
What makes your symptoms better?	



What goals would you like to achieve with physical therapy?	Current Ability
1.	_____/10
2.	_____/10
3.	_____/10

Additional comments for your physical therapist:

Last Updated: 2/6/2025

Informed Consent

I have the right to receive complete and current medical information concerning my diagnosis, treatment, and prognosis. This information will be communicated to me by my provider in terms that I can understand.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol.

ReEnvision does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with your physical therapist throughout your treatment.

It is your right to decline any part of your treatment at any time before or during treatment should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results.

Consequently, it is your right to discuss the potential risks and benefits involved in your treatment. I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

Privacy Practice (HIPPA Acknowledgement/Consent)

I acknowledge that I have received a copy of the Notice of Privacy Practices for ReEnvision. I consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations.

HIPAA Release Form/Benefits

I authorize payment directly to ReEnvision for services and to bill/release payment directly to ReEnvision for any services provided. I hereby assign all benefits directly to ReEnvision. I understand that in the event my insurance company or financially responsible party does not pay for services, I will be financially responsible for payment.

I give permission to ReEnvision to share my medical information and to discuss my medical information with the following people. (i.e. spouse, child, etc). This can be updated at any time with my signature.

I authorize ReEnvision Physical Therapy to share my medical information with the following individuals (e.g., spouse, child):

1. ______________________________ Relationship: ____________________
2. ______________________________ Relationship: ____________________
3. ______________________________ Relationship: ____________________
4. ______________________________ Relationship: ____________________

This authorization is valid for one year unless revoked in writing. I understand that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy regulations.

Patient Name: ____ Date: _____________

Patient/Guardian Signature: ______________________________ Date: _____________

Last Updated: 2/6/2025

AUTHORIZATION FOR RELEASE OF INFORMATION

Printed Name: ____

Address: ____

City: ______________________________ State:___________________ Zip:__________________

Email: __________________________________ Phone: __________________________________

Date of Birth: ___________

HIPAA Authorization

I hereby authorize ReEnvision to use and release my contact information, identified above to:

____

- I understand the information identified above is being used and released in order to provide health management, and other health-related/health education services to me. Except for the information I provided above, no other protected health information will be disclosed by ReEnvision except as I may otherwise request in writing.
- I understand that this authorization will be valid for one year.
- I understand that I may revoke this authorization at any time by notifying ReEnvision in writing to:

ReEnvision Physical Therapy
480 W Jubal Early Dr
Suite 120
Winchester, VA 22601
Attention: Dr. Kyle Feldman

The revocation will be effective on the date notified except to the extent action has already been taken in reliance upon the original authorization.

- I understand that information disclosed to the above organization may be re-disclosed and not protected by the Federal privacy regulations.
- I understand my right to receive services from ReEnvision will not be affected if I refuse to sign this authorization.

Patient/Guardian Initials: _________

Acknowledgment

I acknowledge that I have read this authorization in its entirety (or that it has been read to me), and that I understand and agree to the above.

Agreed and Accepted

Patient/Guardian Signature: __________________________________ Date: ___________

If signed by anyone other than the patient, state the relationship and/ or reason and legal authority to do so:

____

Last Updated: 2/6/2025

Insurance Information

Primary Insurance: ____

Primary Insurance ID Number: ____

Group Number (If applicable): ____

Policy Holder Name: ____

Relationship to Policy Holder: ____________________________ Policy Holder Date of Birth: _______________

Secondary Insurance (if applicable): ____

Secondary Insurance ID Number: ____

Group Number (If applicable): ____

Policy Holder Name: ____

Relationship to Policy Holder: ____________________________ Policy Holder Date of Birth: _______________

Patient and Responsible Party Authorization

I authorize ReEnvision on behalf of ________________________ (your insurance company) to apply for benefits on my behalf for their covered services rendered and request payments from the above-named insurance company be paid directly to REENVISION for the treated person named. I certify that the information reported about my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above-named agent. I permit a copy of this authorization to be used in place of the original. IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN, AND/OR PARENTS RESPONSIBILITY. Patient or responsible party further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest agreed to or that may be adjudicated for the collection of past due debt on accounts for ______________ (your name).

A missed appointment not canceled with 24 hours' notice will be billed $50 for the time allowed and is not covered by insurance. If Medicare and/or my commercial insurance should deny any or all charges, then I agree to be personally and fully responsible for any and all balances due.

Patient/Guardian Signature: ____ Date: ______________

Last Updated: 2/6/2025