ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITUTE
PATIENT REGISTRATION

☐ ALEXANDRIA ☐ ARLINGTON ☐ FAIRFAX ☐ FALLS CHURCH ☐ GREAT FALLS ☐ HERNDON ☐ LEESBURG ☐ TYSONS CORNER

Date

PATIENT INFORMATION (Please Print Clearly)

Name Last	First	Middle	Date of Birth	Age	Sex M F	Social Security No.

Home Address Street	City	State & Zip Code

Home Telephone	Work Telephone	Occupation	Employed By

Employer's Address Street	City	State & Zip Code

PERSON FINANCIALLY RESPONSIBLE / INSURED (Complete Only If Other Than Patient)

Name Last	First	Middle	Relationship to Patient	Date of Birth	Social Security No.

Home Address Street	City	State & Zip Code

Home Telephone	Work Telephone	Occupation	Employed By

Employer's Address Street	City	State & Zip Code

HEALTH INSURANCE INFORMATION

Primary Insurance Co.		Address Street		
City		State & Zip Code		Telephone No.
Policy / ID #	Group #	Name of Policyholder	Date of Birth of Policyholder	Relationship to Patient
Secondary Insurance Co.		Address Street		
City		State & Zip Code		Telephone No.
Policy / ID #	Group #	Name of Policyholder	Relationship to Patient	Is this HMO/PPO? Yes ☐ No ☐

AUTOMOBILE ACCIDENT

Date of Accident	Time [] AM [] PM	Were you [] Driver [] Passenger	Do You Have Medical Benefits Under Your Auto Ins.? Yes No	If Yes, Policy No. / Claim#

Your Automobile Insurance Carrier	Address		Telephone No.
Your Agent's Name	Telephone No.	Your Claim Adjuster's Name	Telephone No.
Other Party's Automobile Carrier	Address		Telephone No.
Other Party's Claim Adjuster's Name	Claim No.		Telephone No.

COMPLETE IF AN ATTORNEY IS REPRESENTING YOU

Attorney's Name	Telephone No.	Fax No.
Address		

WORKMAN'S COMPENSATION (Injury on the Job)

Date of Injury	Claim No.	Compensation Insurance Co.	
Insurance Company Address			
Contact Person's Name			Telephone No.
Employer at Time of Injury			Telephone No.
Was Injury Reported to Supervisor?	Date Reported	Name of Supervisor	Telephone No.

For Office Use Only

Patient/Guardian Signature _____ **Date** _____

PATIENT'S ACCOUNT NO.

PATIENT NAME: _____

EMERGENCY INFORMATION *Who should we notify in case of emergency?*

Nearest Relative/Friend Living With You:	*Name*	*Relationship*	*Home Phone*	*Work Phone*
Nearest Relative/Friend NOT Living With You:	*Name*	*Relationship*	*Home Phone*	*Work Phone*

AUTHORIZATION

I, _____, hereby authorize ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITUTE to apply for benefits on my behalf for covered services rendered by the staff of ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITUTE.

I REQUEST THAT PAYMENT FOR THESE SERVICES BE PAID BY

_____

Insurance Company #1 *S.S. # of Insured / ID* *Group*

and / or _____

Insurance Company #2 *S.S. # of Insured / ID* *Group*

DIRECTLY TO ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITTUE, LLC. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNER THE ABOVE-MENTIONED POLICY / POLICIES.

I certify that the information I have provided above is correct. I further authorize ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITUTE, LLC, to release any necessary information, including medical information, for this or any related claim to the insurance companies named above, or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. This authorization may be revoked by me at any time in writing. I understand that I am responsible for the full settlement of my account regardless of insurance payments or reimbursements.

WITNESS_____ _____ ***DATE***_____

SIGNATURE OF PATIENT, SUBSCRIBER, GUARDIAN OR BENEFICIARY

FINANCIAL POLICIES

For the benefit of our patients, our billing policies are described below.
Payment of the charges for our services is the ultimate responsibility of the patient. Payment is expected at the time services are rendered, except when alternative arrangements are made in advance with us.

PLEASE BE AWARE THAT INSURANCE COMPANIES OFTEN DO NOT FULLY COVER A PHYSICAL THERAPY BILL. THIS MAY RESULT FROM DEDUCTIBLE OR CO-PAYMENT PROVISIONS IN THE PATIENT'S POLICY, OR BECAUSE THE INSURANCE COMPANY HAS ADOPTED A FEE SCHEDULE, OR FOR OTHER REASONS. HOWEVER, AN INSURANCE COMPANY'S FAILURE TO FULLY COVER OUR BILL DOES NOT RELIEVE THE PATIENT OF THE OBLIGATION TO PAY OUR BILL IN FULL.

If you are unable to keep your scheduled appointments, we request that you call and cancel your appointments before your scheduled appointment time and obtain a cancellation#. If you fail to cancel your appointment before your appointment time and do not have the cancellation#, you agree to pay $35.00 missed appointment fee**. This fee is not covered by your insurance company. _____/ Initials**

PLEASE NOTE: During the course of treatment, some patients may require electrical stimulation. As a part of treatment, the use of electrodes may be necessary. These electrodes have contact with the patient's skin and for the patient's safety, patients will be required to purchase his/her own electrodes. The cost to the patient for these electrodes is a ONE-TIME charge of **$16.00 OR $32.00**. Should the therapist deem this treatment necessary, you agree to be responsible for this fee at the time of service. _____/ **Initials**

If our bill is not paid in full when due, we encourage you to discuss with our billing staff alternative payment arrangements that may be acceptable to us. Generally, however, any bill not paid within 90 days will be referred for collection. FOLLOWING 90 DAYS DELINQUENCY, MONTHLY INTEREST CHARGE OF 1.4% WILL ACCRUE ON THE BALANCE AND ALL COLLECTION CHARGES INCLUDING ATTORNEY'S FEES OF 20% ON THE UNPAID BALANCE AND COURT COSTS WILL BE ADDED TO THE PATIENT'S ACCOUNT. Please indicate that you have read and understood the foregoing billing policies by signing below.

_____ _____

PATIENT'S PRINTED NAME PATIENT'S/RESPONSIBLE PARTY'S SIGNATURE

_____ _____

ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITUE DATE

ACE Physical Therapy & Sports Medicine Institute
Physical Therapy, Sports, Post-op and Work Rehabilitation

Consent Agreement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we inform you of our policy regarding the protection of your health information through our Privacy Notice. Please refer to our Privacy Notice, which is available to you along with this consent agreement, for a full explanation of how this office will protect your health information. You may print or view a copy of the notice through our website at: www.ace-pt.org, by clicking on the **Notice of Privacy Practices** link.

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I, _____, have been presented with a Privacy Notice explaining my rights regarding my protected health information. I consent to the use and/or disclosure of my protected health information for the purposes of treatment, payment or other health care operations (TPO). If I require the services of an in-house and/or outside language interpreter*, my protected health information may be disclosed in order to provide effective and efficient medical treatment.

_____ _____
Patient's Name Witness

_____ _____
Patient/Responsible Party's Signature Date

*Outside interpreter's name: _____

Address: _____

_____

Phone: _____

2841 Hartland Rd, # 401B • Falls Church, VA 22043 • (703) 205-1233
108 Elden Street, #12 • Herndon, VA 20170 • (703) 464-0554
19465 Deerfield Ave, #311 • Leesburg, VA 20176 • (703) 726-9702
12011 Lee Jackson Memorial Hwy, #101 • Fairfax, VA 22030• (703) 273-4616
2877 Duke Street • Alexandria, VA 22314• (703) 212-8221
8230 Boone Blvd, #202 • Vienna, VA 22182• (703) 288-9066
1701 Clarendon Blvd, #110• Arlington, VA 22209 • (703) 205-1237

Ace Physical Therapy & Sports Medicine Institute

Subjective Report/PMHX Form

(Page 1 of 1)

Patient Name: _____ **Ht:**_____ **Wt:**_____ **Hand dominance:** _____

What is your chief complaint? _____

What is your email? _____

How did you hear about this company? _____

What is your date of injury/onset of symptoms? _____

How and where did you injure yourself? _____

Have you had any of the following? ☐ **X-rays** ☐ **CT Scan** ☐ **MRI** ☐ **EMG/Nerve Conduction Test**

Did you have surgery? ☐ **Yes** ☐ **No** **Date of surgery**_____

Who is your referring Doctor?_____ **When is your next Doctor's visit?** _____

Have you had any prior treatment for this injury? ☐ **Yes** ☐ **No**

If yes, explain: _____

What makes your problem BETTER? _____

What makes your problem WORSE? _____

Therapist Comments:

EASI score

Depression score

Fall Risk

Functional Outcome Score

BMI-

Diagnosis: _____

Surgical Procedure: _

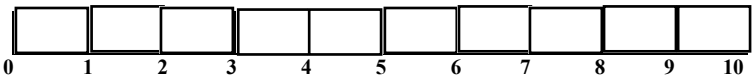
_____

Date of surgery: _____

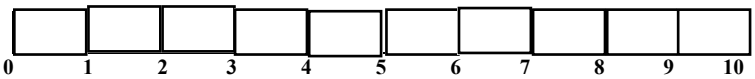
Pain Rating:

If you have pain, what is your pain level? **(0 = No Pain, 10 = Extreme Pain)**

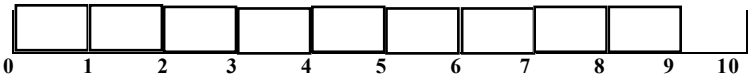
Pain Level at WORST: (Circle)



CURRENT Pain Level : (Circle)



Pain Level at BEST: (Circle)



If you do have pain, please describe your symptoms to the best of your ability (ie. numbness, tingling, pins and needles, etc) _____

Have you fallen in the past 12 months? ☐**Yes** ☐ **No** **If yes, how many times?** _____

If yes, please describe if an injury(ies) occurred:

_____

How would you classify your general health? □

Good ☐ **Fair** ☐ **Poor** ☐

What is your occupation? _____ **Are you presently working?** ☐**Yes** ☐**No**

If Yes, ☐**Full** ☐**Limited Duty** **Lost days from work to date:** _____**Days of work restriction to date:** _____

Are you now, or ever have been disabled (service or work)? □ **Yes** □ **No** **If yes, when?** _____

Do you Smoke ☐ **Yes** ☐ **No** **If Yes please explain, since duration, type, no of smokes/day etc**_____

Is there any other information regarding your medical history that we should know about? _____

Patient's Goals for PT/OT: **What are your goals for participating in physical therapy?**_____

_____

To the best of my knowledge, I have fully informed you of the history of my problem and current status.

Patient Signature: ☑_____ **Date:** _____

Therapist Signature:_____ **Date:** _____

Are you currently taking ANY kind of medication(s)? ☐ **No** ☐ **Yes** If yes, please list below:
(Please list ALL prescription, over-the counter, herbal, and vitamin/mineral/dietary (nutritional) supplements)

If you do not remember the dosage and frequency, please indicate with a question (?) mark

Name	Dosage	Frequency	Route of Administration (Check as applicable)		
			Oral	Injection	Topical

To the best of my knowledge/ability, I have listed all current medications, its dosage, frequency and route of administration

Patient Signature: ☑_____ **Date:** _____

Therapist Signature: _____ **Date:** _____

ACE Physical Therapy & Sports Medicine Institute

ELDER ABUSE SUSPICION INDEX © (EASI)

EASI Questions Q.1-Q.5 asked of patient; Q.6 answered by doctor (*Within the last 12 months)*			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	DID NOT ANSWER
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	DID NOT ANSWER
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	DID NOT ANSWER
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	DID NOT ANSWER
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	DID NOT ANSWER
6) **Doctor:** Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	DID NOT ANSWER

Mark J. Yaffe, MD McGill University, Montreal, Canada
Maxine Lithwick, MSW CSSS Cavendish, Montreal, Canada
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ACE Physical Therapy & Sports Medicine Institute

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date:_____

Instructions: Choose the best answer for how you felt over the past week.

No.	Question	Answer	Score
1)	Are you basically satisfied with your life?	YES / ***NO*** ☐ ☐	
2)	Have you dropped many of your activities and interests?	***YES*** / NO ☐ ☐	
3)	Do you feel that your life is empty?	***YES*** / NO ☐ ☐	
4)	Do you often get bored?	***YES*** / NO ☐ ☐	
5)	Are you in good spirits most of the time?	YES / ***NO*** ☐ ☐	
6)	Are you afraid that something bad is going to happen to you?	***YES*** / NO ☐ ☐	
7)	Do you feel happy most of the time?	YES / ***NO*** ☐ ☐	
8)	Do you often feel helpless?	***YES*** / NO ☐ ☐	
9)	Do you prefer to stay at home, rather than going out and doing new things?	***YES*** / NO ☐ ☐	
10)	Do you feel you have more problems with memory than most people?	***YES*** / NO ☐ ☐	
11)	Do you think it is wonderful to be alive?	YES / ***NO*** ☐ ☐	
12)	Do you feel pretty worthless the way you are now?	***YES*** / NO ☐ ☐	
13)	Do you feel full of energy?	YES / ***NO*** ☐ ☐	
14)	Do you feel that your situation is hopeless?	***YES*** / NO ☐ ☐	
15)	Do you think that most people are better off than you are?	***YES*** / NO ☐ ☐	
Total			

(Sheikh & Yesavage, 1986)

Scoring:
Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.

Sources:

• Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. *Clin Gerontol*. 1986 June;5(1/2):165-173.
• Yesavage JA. Geriatric Depression Scale. *Psychopharmacol Bull*. 1988;24(4):709-711.
• Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale:a preliminary report. *J Psychiatr Res*. 1982-83;17(1):37-49.

ACE Physical Therapy & Sports Medicine Institute

STAY INDEPENDENT QUESTIONNAIRE

Check Your Risk for Falling

Q no	Circle "Yes" or "No" for each statement below			Why it matters
1)	Yes (2)	No (0)	I have fallen in the past year	People who have fallen once are likely to fall again.
2)	Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
3)	Yes (1)	No (0)	**Sometimes I feel unsteady when I am walking.**	Unsteadiness or needing support while walking are signs of poor balance.
4)	Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
5)	Yes (1)	No (0)	**I am worried about falling**.	People who are worried about falling are more likely to fall.
6)	Yes (1)	No (0)	I need to push my hands from a chair to stand up	This is a sign of weak leg muscles, a major reason for falling.
7)	Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
8)	Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
9)	Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
10)	Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
11)	Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
12)	Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total: _____/**14**			Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.

ACE Physical Therapy & Sports Medicine Institute

COVID-19 Pandemic Treatment Consent Form

Patient's Last Name:_____First Name:_____ MI:___

**** We are requesting all patients wear a mask at the time of their visit ****

We have numerous guidelines in place to minimize the risk of transmission. Nonetheless, it is still possible to contract COVID-19 while at a medical office.

I knowingly and willingly consent to have treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious._____(initial)

I understand that due to the frequency of visits of other patients, the characteristics of the COVID-19 virus, and the characteristics of medical procedures, I have an elevated risk of contracting the COVID-19 virus simply by being in a medical office._____(initial)

I confirm that I am not presenting any of these COVID-19 symptoms – fever, shortness of breath, dry cough, runny nose, sore throat._____(initial)

I confirm that I have not been in contact with a person who has been diagnosed with COVID-19 within the past 14 days._____(initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus, and that the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with medical treatment._____(initial)

I verify that I have not traveled outside the United States in the past 14 days._____(initial)

I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days._____(initial)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of any changes in medical status.

Relationship to patient: ☐ Self ☐ Parent

Signature: _____

Date:_____/_____/_____

Ver1.0- 08.2020