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 48 hours 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 $75.00 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.

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
 10123 Colvin Run Road • Great Falls, VA 22066 • (703) 759-7820

PHYSICAL THERAPY VESTIBULAR & BALANCE EVALUATION

INTAKE INFORMATION

Date: _____

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

Physician: _____ **Date of birth**: _____ **Date of onset**: _____

Diagnostic tests: ☐ VNG/Galvanic ☐ MRI/CT _____

Surgical procedure: _____ **Date of surgery**: _____

Return doctor's visit: _____

Past medical history: ☐ Heart Con

☐ Headaches ☐ History of Mig

☐ Head Trauma ☐ Multiple Sclerosis ☐ CVA/Stroke ☐ Other: _____

_____

Social history: ☐ Smoke ☐

Emergency Contact Name: _____**Number**: _____

HISTORY OF PRESENT ILLNESS/SUBJECTIVE

Chief complaint: _____

_____

Setting in which Symptoms first occurred: _____

Description of Symptoms: ☐ Balance ☐ Vertigo (sensation of spinning) ☐ Lightheadedness/faint ☐ off

Symptoms are getting: ☐ better ☐ episodic ☐ worse ☐ same

Description of Spells: ☐ constant ☐ spontaneous ☐ induced by motion ☐ induced by position changes ☐ other

Length of time spells occur: ☐ seconds ☐ minutes ☐ hours ☐ days ☐ other _____

What increases symptoms? _____

What decreases symptoms? _____

Hearing impairments: ☐ yes ☐ no ☐ Explain _____

Changes in hearing since onset: ☐ yes ☐ no ☐ Explain _____

Visual changes since onset: ☐ yes ☐ no ☐ comments _____

Recent falls: ☐ yes ☐ no ☐ comments _____

History of migraines: ☐ yes ☐ no ☐ comments _____

Previous treatments: _____

Job requirements/work status: _____

Other: _____

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

Therapist Signature: _____ **Date:** _____

Musculoskeletal Screen:

- Cervical: ☒WNL ☐Limited:
- LE Strength: ☐ WNL ☐ Weakness: _____

Auditory Screen:

- Weber ☐Negative ☐Lateralizes: Right/ Left
- Rinne ☐Air Conduction > Bone Conduction ☐Bone Conduction > Air Conduction

Somatosensory Testing

- Sensation:
  - Left LE : ☐WNL/intact ☐Diminished ☐Absent
  - Right LE : ☐WNL/intact ☐Diminished ☐Absent
- Proprioception:
  - Left LE : ☐WNL/intact ☐Impaired ☐Absent
  - Right LE : ☐WNL/intact ☐Impaired ☐Absent
- Coordination:
  - Rapid Alternating movements
    - Alternating foot taps: ☐ WNL ☐Dysdiadochokinesia
    - Heel to shin: ☐ WNL ☐Dysdiadochokinesia
    - Alternating hand taps: ☐ WNL ☐Dysdiadochokinesia
    - Alternating supination/pronation: ☐ WNL ☐Dysdiadochokinesia

Postural Control Tests:

- Balance (Romberg):
  - Standing level/ firm surface Eyes Open: ☐WNL ☐Sway: Mild/ Moderate/ Severe / LOB
  - Standing level/ firm surface Eyes Closed: ☐WNL ☐Sway: Mild/ Moderate/ Severe / LOB
- CTSIB:
  - Standing on foam Eyes Open: ☐WNL ☐Sway: Mild/ Moderate/ Severe / LOB
  - Standing on foam Eyes Closed: ☐WNL ☐Sway: Mild/ Moderate/ Severe / LOB
- Fukuda Step test
  - + / -
  - Direction: Right / Left

Gait

- Standard: ☐WNL ☐Unsteady
- With head vertical movements: ☐WNL ☐Unsteady
- With head horizontal rotation: ☐WNL ☐Unsteady
- Tandem Gait: ☐ WNL ☐Unsteady
- Comments:_____

Oculomotor Testing:

- Smooth Pursuits (H-test): ☐WNL ☐ Saccadic ☐Abnormal ocular ROM
- Saccades (Nose to finger): ☐WNL ☐Abnormal
- Head Thrust: ☐WNL ☐Positive: Right/ Left / Bilateral
- Heave Test: ☐WNL ☐Positive: Right/ Left / Bilateral
- Gaze Stability with fixation:
  - ☐negative
  - ☐1° ☐2° ☐3° Nystagmus: Right / Left
- Gaze Stability without fixation: (use of infrared goggles)
  - ☐negative
  - ☐1° ☐2° ☐3° Nystagmus: Right / Left
- Visual Acuity
  - Static: Line #: _____
  - Dynamic: Line #: _____

Vestibular Testing

- Head Shake without fixation (10 sec): ☐negative ☐Nystagmus: Right / Left
- Hyperventilation without fixation (40 sec): ☐negative ☐Nystagmus: Right / Left
- Vibration Induced Nystagmus:
  - Right: ☐Nystagmus: Right / Left ☐ No nystagmus
  - Left: ☐Nystagmus: Right / Left ☐ No nystagmus
- Valsalva Induced Dizziness:
  - ☐ Patient reported: Yes / No ☐Nystagmus: + / - Direction:_____
- Positional Testing:
  - Dix-Hallpike
    - Right: ☐ Negative ☐Nystagmus: Right/ Left Torsional, Up-beating / Down-beating
      - Duration of nystagmus: _____
      - Return to sit _____
      - Associated complaints of dizziness? _____
    - Left: ☐ Negative ☐Nystagmus: Right/ Left Torsional, Up-beating / Down-beating
      - Duration of nystagmus: _____
      - Return to sit _____
      - Associated complaints of dizziness? _____
  - Roll Test:
    - Right: ☐ Negativ
    - Left: ☐ Negati

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:** _____