



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	<input type="checkbox"/> AM <input type="checkbox"/> PM	Were you		<input type="checkbox"/> Driver <input type="checkbox"/> Passenger	Do You Have Medical Benefits Under Your Auto Ins.?	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?*

<i>Nearest Relative/Friend Living With You:</i>	<i>Name</i>	<i>Relationship</i>	<i>Home Phone</i>	<i>Work Phone</i>
<i>Nearest Relative/Friend NOT Living With You:</i>	<i>Name</i>	<i>Relationship</i>	<i>Home Phone</i>	<i>Work Phone</i>

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 _____

SIGNATURE OF PATIENT, SUBSCRIBER, GUARDIAN OR BENEFICIARY

DATE _____

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 INSTITUTE

DATE



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

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? _____

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) _____

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? _____

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

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: _____

Therapist Comments:

Pain assessment

Fall Risk

Functional Outcome Score

BMI-

Diagnosis: _____

Surgical Procedure: _____

Date of surgery: _____

