ACE PHYSICAL THERAPY
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,LLC to apply for benefits on my behalf for covered services rendered by the staff of ACE PHYSICAL THERAPY.
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, 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** working 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

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: _____

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108 Elden Street # 12 • Herndon, VA 20170 •
19465 Deerfield Ave, #311 • Leesburg, VA 20176 •
12011 Lee Jackson Memorial Hwy, #101 • Fairfax, VA 22030•
2877 Duke Street • Alexandria, VA 22314•
8230 Boone Blvd, #202 • Vienna, VA 22182•
1701 Clarendon Blvd, #110• Arlington, VA 22209 •

Ace Physical Therapy

Subjective Report/PMHX Form

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

Email: _____ **How did you hear about this company?** _____

What are your symptoms? _____

When did symptoms start? (Onset Date) _____ **Surgery Date** _____ **Where did you have surgery?** _____

Cause of symptoms? _____

Since onset, your symptoms are: ☐ **Worse** ☐ **Same** ☐ **Better** **Prior to this onset, were you symptom free?** ☐ **Yes** ☐ **No**

Please rate your current pain (circle): (No pain) (Moderate) (Worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Daily Activities: Home/Leisure Limitations_____

Self-Care Limitations_____

Do you exercise? _____ **How often?** _____ **Type** _____

How has your lifestyle/quality of life been altered/changed because of this problem? Social activities (exclude physical activities), specify
Diet /Fluid intake, specify
Physical activity, specify Work, specify

Since the onset of your current symptoms have you had:

☐Y/N☐ Fever/Chills
☐Y/N☐ Unexplained weight change
☐Y/N☐ Dizziness or fainting
☐Y/N☐ Change in bowel or bladder functions
☐Y/N☐ Other /describe _____
☐Y/N☐ Malaise (unexplained tiredness)
☐Y/N☐ Unexplained muscle weakness
☐Y/N☐ Night pain/sweats
☐Y/N☐ Numbness / Tingling

☐Date of Last Physical Exam _____ Tests performed _____

_____

Ob/Gyn History (Females Only)			
☐Yes ☐No	Births: vaginal # ____ c-section #____	☐Yes ☐No	Episiotomy #____
☐Yes ☐No	Difficult childbirth	☐Yes ☐No	Pelvic/genital pain
☐Yes ☐No	Vaginal dryness	☐Yes ☐No	Hysterectomy
☐Yes ☐No	Pregnant or attempting pregnancy	☐Yes ☐No	IUD in place
☐Yes ☐No	Prolapse/Rectocele/Cystocele	☐Yes ☐No	Endometriosis
☐Yes ☐No	Painful Menstruation/sex	☐Yes ☐No	Menopause - When?
What form of birth control do you use?		Date of your last period-	
Age when you had your 1st periods-		How often do you have a period(In days)-	
On average how long does your period lasts(In days)-		Any pain with periods, if yes- Medications taken-	
Any Abortions/Miscarriage ☐Yes ☐No If yes, How many-		Diagnosed with infertility? ☐Yes ☐No If yes, having treatment ☐Yes ☐No	

☐ Sexually Inactive due to PAIN ☐ Sexually inactive -other reasons ☐ Sexually active

Any history of sexual abuse-

If you are sexually active, continue with this section

Pain with intercourse	☐Yes ☐No
Pain with intercourse, able to complete sex	☐Yes ☐No
Pain with intercourse prevents any attempt to have sex	☐Yes ☐No
Tolerate manual/oral stimulation only –no penetration	☐Yes ☐No

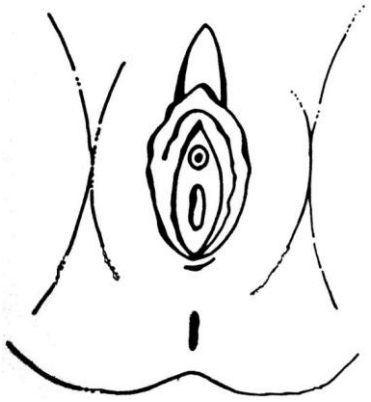
Check ALL the activities that cause or increase your pain:

☐Gynecological Examination with Speculum
☐Finger insertion into vagina
☐Tampon removal
☐Friction with clothing
☐Urination in general
☐Masturbation alone
☐Urination after intercourse
☐Tampon insertion
☐Partner manual stimulation
☐Sports activity
☐Oral stimulation by partner
☐Wearing pads
☐ Other_____

What makes your pain feel better?

_____

Please mark with an "X" where your pain begins. Shade any other areas of pain



Males Only			
☐Yes ☐No	Prostate disorders	☐Yes ☐No	Erectile Dysfunction
☐Yes ☐No	Shy bladder	☐Yes ☐No	Able to ejaculate
☐Yes ☐No	Pelvic/genital pain	☐Yes ☐No	Painful Ejaculation
Other pelvic problems, List-		☐Yes ☐No	Hernia – Where?

Bladder Symptoms

☐Yes ☐No	Trouble initiating urine stream	☐Yes ☐No	Dribbling after urination
☐Yes ☐No	Urine intermittent/slow stream	☐Yes ☐No	Constant urine leakage
☐Yes ☐No	Strain or push to empty bladder	☐Yes ☐No	Trouble feeling bladder urge/fullness
☐Yes ☐No	Need to urinate with little warning	☐Yes ☐No	Recurrent bladder infections
☐Yes ☐No	Trouble emptying bladder completely	☐Yes ☐No	Painful urination
☐Yes ☐No	Blood in urine	☐Yes ☐No	Volume passed __small __med __large

Urinary Habits

Frequency of urination: Every ____minutes; Every ____ hours; ____times per day; ____times per night

On average, how much do you leak? ☐None ☐Just a few drops ☐Wet underwear ☐Wet the floor ☐Soaked pads

Can you delay before you go to toilet? _____ minutes (# of minutes) _____hours (# of hours) ☐Not at all

Bladder leakage: # of episodes: ☐None ☐without awareness ☐with exertion/cough ☐with urge
____times/day; ____times/week; ____times/month

What form of protection do you wear? ☐None
☐Minimal protection (toilet paper/pantishield)
☐Moderate protection (absorbent product/maxipad)
☐Maximum protection (specialty product/diaper)

On average, how many pad changes are required during daytime? _____(#of pads) **at night?**____(#of pads)
Are they damp____ wet _____ soaked_____

Average fluid intake (1glass = 8 oz) ____# glasses/day
Of this total how many glasses are: ☐Caffeinated? ____# glasses/day ☐Fruit drinks? ____# glasses/day
☐Alcoholic? ____# glasses/day ☐Water? ____# glasses/day

Bowel History

☐Yes ☐No	Blood in bowel movement (BM)	☐Yes ☐No	Trouble emptying bowel completely
☐Yes ☐No	Painful BM	☐Yes ☐No	Need to support/splint to complete BM
☐Yes ☐No	Trouble feeling bowel urge	☐Yes ☐No	Constipation/straining ____% of time
☐Yes ☐No	Trouble holding back gas	☐Yes ☐No	Current laxative use
☐Yes ☐No	Trouble starting BM	☐Yes ☐No	Fecal leakage ___times/day ___times/week

Comments:

Bowel Symptoms

Frequency of bowel movements: ____times/day; ____times/week

When you have the urge to have a bowel movement, how long can you delay? ☐Minutes ☐Hours ☐Not at all

Bowel movements are typically: ☐ Watery ☐ Loose ☐ Formed ☐ Pellets ☐ Thin ☐ Hard

If constipation is present, describe management techniques:

Comments:

Medical History:

MEDICATIONS & ALLERGIES

Please list (or provide us with a separate list) of any medications you are currently taking and any allergies you have

MEDICATION:			
☐ Refer to attached medication list provided by patient			
ALLERGIES:			

MEDICAL DIAGNOSES AND CONDITIONS

Please check those *current or past* items that apply to you

General Health	☐ Fatigue ☐ Weight change ☐ Fever ☐ Chills ☐ Night sweats ☐ Recent illness ☐ Excess Thirst ☐ Cancer ☐ Diabetes ☐ Thyroid problem ☐ Bleeding ☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ Back Pain
Lungs/Breathing	☐ Coughing ☐ Asthma ☐ Allergy ☐ Emphysema ☐ COPD ☐ Smoker (if yes, how many packs per day? _____)
Gastrointestinal/ Stomach/Urinary	☐ Nausea ☐ Vomiting ☐ Kidney disease ☐ Hiatal hernia ☐ Reflux ☐ Heartburn ☐ Trouble swallowing ☐ Irritable bowel syndrome ☐ Constipation ☐ Diarrhea ☐ Interstitial cystitis
Genitourinary	☐ Currently pregnant (If yes, how many weeks?)_____ ☐ Incontinence (circle) Bladder/Bowel ☐ Prostate problems ☐ Infections ☐ Frequent or painful urination
Musculoskeletal	☐ Back/neck/joint problems ☐ Osteoporosis
Skin	☐ Rash ☐ Bruise easily ☐ Open sores ☐ Recent tattoos ☐ Psoriasis ☐ Eczema
Neurological	☐ Stroke ☐ Parkinson's ☐ MS ☐ Fibromyalgia

Please list any other Conditions not noted above:

What previous treatments or tests have you had?

☐ X-Rays ☐ CT Scan ☐ MRI ☐ Injections ☐ EMG ☐ Other _____

Please list any surgeries you have had and when:

Rate a feeling of organ "falling out"/prolapse or pelvic heaviness/pressure

☐ None present	☐ With standing for ____minutes or ____hours
☐ With exertion or straining	☐ With menses
☐ Pressure at end of the day	☐ Pressure all day
Comments:	

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:** _____

Ace Physical Therapy

Subjective Report/PMHX Form

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:** _____

HEALTH INSURANCE BENEFITS AND RESPONSIBILITIES**

Patient Name: _____

We contacted your insurance company at _____ (phone#) and spoke to their representative, on _____. Following is the information that was quoted to us regarding your physical therapy benefits:

WE WERE TOLD THAT THESE BENEFITS WERE NOT A GUARANTY OF PAYMENT. The final determination will be made by your insurance company upon receipt of the physical therapy claims and after determining medical necessity. Please note that at the time of each visit, you will pay based on the benefits that have been quoted to us. You will receive a final bill, if any, based on the processing of your insurance claims.

Deductible	Physical Therapy benefits as quoted by your insurance **$ Met: $**
Co-Insurance / Co-Pay Per Visit	
Max Benefit Limit, if any ($Amount or #of Visits)	
Does PT need a referral?	☐ Yes ** ☐ No
Does PT require Pre- Certification?	☐ Yes ** ☐ No
Biofeedback/Estim/Disposable Electrodes charges not covered by insurance	**$25/visit**

**If your insurance company requires a Referral or Pre-Certification for Physical Therapy, please make sure that it has been obtained prior to starting your physical therapy. Please be aware that the Referral and/or Pre-certification usually have a visit and time duration limitation. Our staff will be glad to assist you in renewing your Referral and/or Pre-certification. Please let your Physical Therapist know, when you have 2 visits remaining so that there is adequate time to get the paperwork sent to your insurance company and or your treating doctor. If you continue to receive physical therapy after the expiration of your Referral and/or Pre-certification, your insurance will not make any payment on those bills and you will be responsible for the full payment.

☑ _____ _____
Patient/Guardian Signature and Printed Name Date

Based on the benefits that were quoted by your insurance, you need to prepay $ 25 EVERY VISIT (FOR DISPOSABLE PH ELECTRODES/ BIOFEEDBACK) each time services are rendered. Please provide us your credit card information to keep it on file to pay your copayment / coinsurance and any balance that is 30 days or more past due, please authorize by completing the information below:

Circle one. ☐VISA ☐MASTERCARD *Credit Card Holder's Name:_____

*Credit Card Number:_____Exp. Date: _____, CVV Code_____

Billing Address and Zip Code_____

☑ _____ _____
Patient/Guardian Signature and Printed Name Date

Advance Beneficiary Notice

Your physical therapist/physician has determined that it is in your best interest to use **Biofeedback and Electrical stimulation with disposable electrode charges** as a part of treatment for your condition for your rehabilitation program. Our charge for the Biofeedback/E stim is **$25.00/session** over & above your regular physical therapy copay/co-insurance charges.

We have been informed by your insurance company that they do not pay for these charges. Your insurance company will not pay for E stim/Biofeedback for Pelvic floor rehabilitation because it is considered an experimental procedure with insufficient evidence of its effectiveness. The fact that your insurance company will not pay for this service does not mean that you should not receive it. There is a good reason your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you will have to pay for them yourself, "out-of-pocket". Before you make a decision about your options, please ask us to explain the benefits of these services and **read this notice carefully.**

By signing below, you are agreeing that:

☐ **YES, I want to receive these items or services.** I understand that because E stim/Biofeedback for Pelvic floor rehabilitation is considered an experimental procedure with insufficient evidence of its effectiveness, your insurance company will NOT pay for it. I agree that my insurance company cannot be billed for these services. I remain personally and fully responsible for payment of these services.

☐ **NO, Reason:** **A. Cost**
B. Experimental Procedure

_____ _____
Signature of patient Date

_____ _____
Patient name (printed) Witness

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