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, LLC.
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, 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 every 5th visit and you will be responsible to pay a charge of $16 every 5th visit ☑_____**/ 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 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

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 _____

_____

Current Sexual Activity:

☐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

☐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?

Check ALL the activities that cause or increase your pain:

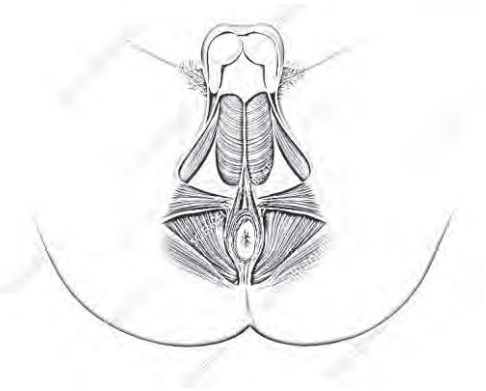
__Urological/PCP DRE Examination
__Any insertion into Rectum
__Friction with clothing
__Urination in general
__sitting
__Other_____

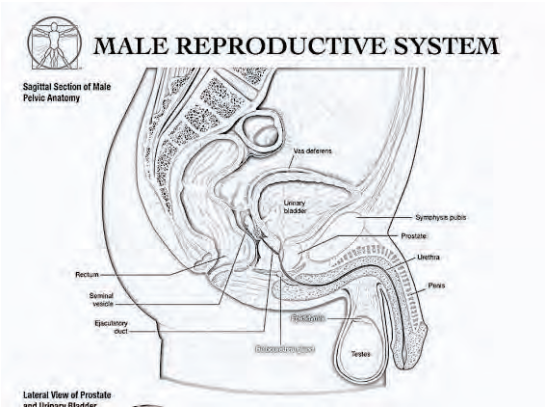
__Urination after intercourse
__Partner manual/Oral stimulation
__Sports activity
__Masturbation alone
__wearing tight clothes

What makes your pain feel better?

_____

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





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)
☐Moderate protection (absorbent product)
☐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

☐ 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	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?_____)
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:

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:** _____