ACE PHYSICAL THERAPY
PATIENT REGISTRATION

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

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 appointment 24hrs 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-$32.00** (A4556 CPT CODE). Should the therapist deem this treatment necessary, **this fee is not covered by your insurance company. _____/ 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

Ace Physical Therapy, LLC
Subjective Report/PMHX Form

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:

Pain assessment

Fall Risk

Functional Outcome Score

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)

0	1	2	3	4	5	6	7	8	9	10

CURRENT Pain Level : (Circle)

0	1	2	3	4	5	6	7	8	9	10

Pain Level at BEST: (Circle)

0	1	2	3	4	5	6	7	8	9	10

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? _____

Medications: **Please list all of the medications (with specific dosages) that you are currently taking (including over the counter, prescriptions, herbals, and vitamins/minerals :)**

_____

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:** _____

ACE Physical Therapy

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
If Pre-Cert is Reqd, Pre-Cert Dept Phone#	
Electrodes **One time charge***	* $16.00 or $32.00

**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 $_____ each time services are rendered. If you would like us to keep your credit card 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:_____ExpDate: _____, CVV Code_____

Billing Address and Zip Code_____

_____ _____

Patient/Guardian Signature and Printed Name Date

ACE Physical Therapy

PHYSICAL THERAPY VESTIBULAR & BALANCE EVALUATION

INTAKE INFORMATION **Date**: _____

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

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

Diagnostic tests: ☐ VNG/Caloric ☐ MRI/CT ☐ Audiogram ☐ other _____

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

Return doctor's visit: _____

Past medical history: ☐ Heart Conditions ☐ High Blood Pressure ☐ Hypotension ☐ Diabetes ☐ High Cholesterol ☐ Headaches ☐ History of Migraines ☐ History of infection ☐ Recent antibiotic use ☐ Osteoporosis ☐ Falls ☐ Head Trauma ☐ Multiple Sclerosis ☐ CVA/Stroke ☐ Other: _____

_____

Social history: ☐ Smoke ☐ Drink: amount/how often _____ ☐ History of heavy regular drinking

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

HISTORY OF PRESENT ILLNESS/SUBJECTIVE

Chief complaint: _____

_____

Setting in which Symptoms first occurred: _____

Description of Symptoms: ☐ vertigo (sense of spinning) ☐ off-balance ☐ lightheadedness/faint

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

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: ☐ Negative ☐ Nystagmus: Geotropic / Ageotropic ☐ Duration _____
    - Left: ☐ Negative ☐ Nystagmus: Geotropic / Ageotropic ☐ Duration _____

Ace Physical Therapy,LLC

Subjective Report/PMHX Form

Are you taking ANY kind of medication now? ☐ **No** ☐ **Yes** If yes, please list below.
(Please list ALL prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements)

☐ I do not remember name/dosage/frequency of my medications (Please circle whatever applicable)

Medication Name	**Dosage & frequency**	**Route of administration(Please circle whatever applicable)**
		Oral/Injection/Topical application
		Oral/Injection/Topical application
		Oral/Injection/Topical application
		Oral/Injection/Topical application
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		Oral/Injection/Topical application
		Oral/Injection/Topical application

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:** _____