



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 <input type="checkbox"/> Driver <input type="checkbox"/> 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

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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: _____

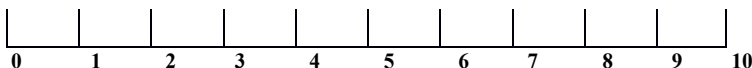
What makes your problem BETTER? _____

What makes your problem WORSE? _____

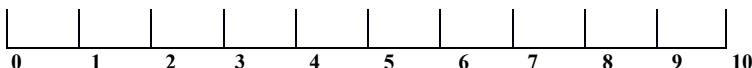
Pain Rating:

If you have pain, what is your pain level? (0 = No Pain, 10 = Extreme Pain)

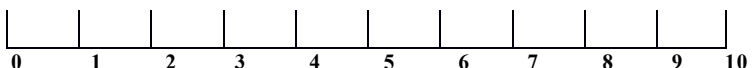
Pain Level at **WORST**: (Circle)



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? _____

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: _____

Therapist Comments:

Pain assessment

Fall Risk

Functional Outcome Score

Diagnosis: _____

Surgical Procedure: _____

Date of surgery: _____

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