ProMotion PHYSICAL THERAPY

6849 Old Dominion Drive, Ste . 330 McLean, VA 22101
Phone: (703) 848-9333 Fax: (703) 848-0660
E - mail: info@pro-motionpt.com

PATIENT REGISTRATION FORM

□ New Patient □ Returnning Patient

PATIENT INFORMATION

Patient's Last Name	First	Middle Initial	Sex ☐ M ☐ F	Date of Birth

Street Address	City	State	Zip Code	Social Security #

Home Phone	Cell Phone	Check the box for the best day time number ☐ Home ☐ Cell

List name of guardian/payor (if other than self) Last	First	Phone Number

E-mail Address	May we contact you via e-mail regarding appointments/benefits/our newsletter? ☐ Yes ☐ No	How did you here about us? □ Returning Patient □ Friend/Family Member □ Doctor □ Other_____

Referring Physician Name Last	First	Worker's Compensation ☐ Yes ☐ No	Auto Accident ☐ Yes ☐ No	Date of Injury/Accident / /

Please give a brief description of the problem

PRIMARY INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST)

Primary Insurance Name	Policy Number	Group Number

If Medicare, have you had physical/speech therapy this calendar year? ☐ Yes ☐ No

Policy Holder's Name	Your relationship to policy holder ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Date of Birth / /

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Relationship to emergency contact	Phone Number	Alternate Number

I certify that the above information is true to the best of my knowledge. I authorize Pro Motion Physical Therapy, LLC to release the information required to process my claims and authorize my insurance benefits be paid directly to Pro Motion Physical Therapy, LLC. I understand that I am financially responsible for any remaining balance.

Signature _____ Date _____

MEDICARE ONLY:

Have you had any physical therapy this calendar year?_____

MEDICARE ONLY: Cap Left$_____ Visits Left _____		Additional notes: _____ _____ _____
Benefits explained to patient on _____ by _____		

ProMotion PHYSICAL THERAPY

Patient's History of Current Injury/Illness

Name: _____ **Today's Date**: _____

Age: _____ **Date of Birth**: _____ **Sex**: _____ **Occupation**: _____

Ht._____ **Wt**. _____ **BP**_____ **HR** _____ (office use only)

How did you hear about us? _____

History of present condition: (when did your symptoms start, can you identify a cause, have you seen any other health care providers for this issue?)

_____

_____

_____

Chief complaint at this time:

_____

_____

_____

Current functional level (what are you having difficulty with due to pain):

_____

_____

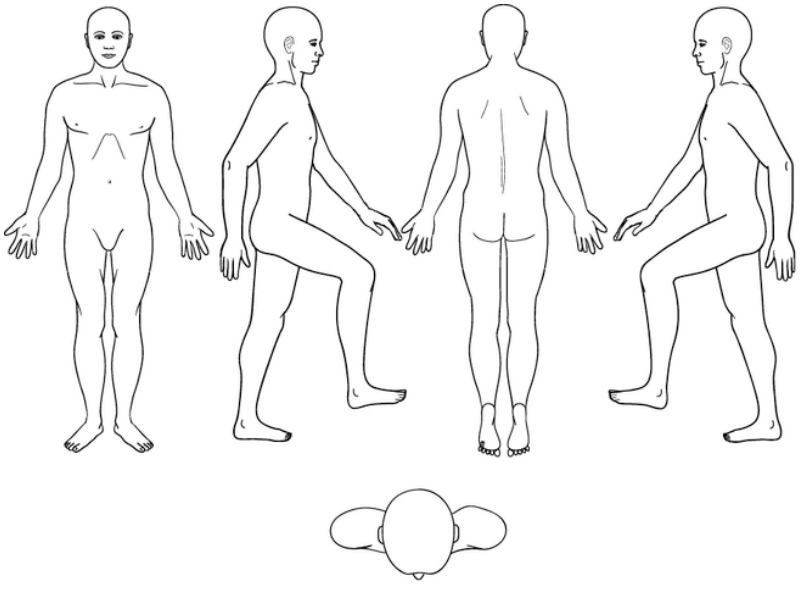
_____

Pain rating*:* Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain free *Unconscious Pain*

Please use the body diagram to the right and Shade Areas of Pain



Patient's History of Current Injury/Illness

How would you describe your pain? (please check all that apply)

___ Burning
___ Sharp
___ Dull/Achy
___ Throbbing
___ Shooting
___ Numbness
___ Tingling

Do you have numbness, tingling, or weakness? □ Yes □ No

If yes, please describe: _____

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? □ Yes □ No

Describe _____

What activities/positions make your pain worse? _____

_____

What activities/positions make your pain better? _____

_____

Have you had any diagnostic tests? □ Yes □ No

If yes what tests, and what are the findings (ex: X-rays, MRI, bloodwork):

Have you had any falls in the past 6 months? □ Yes □ No **Did it result in an injury?** □ Yes □ No

Please list three functional goals that you have for PT: (ex; walking 30 mins, turning in bed, or reaching top shelf)

1. _____

2. _____

3. _____

Medication Record:

Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements).

If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation _____ (Patient initials)

Medication	Dosage	Reason for Taking

Patient's History of Current Injury/Illness

Use additional sheet if more space is needed

Medical History: Please check all categories that apply to your medical history

Condition		Comment/Dates	Condition		Comments/Dates
Respiratory			Stroke		
Cardiac			Seizures		
Pacemaker			Skin Problems		
Diabetes			Psychiatric		
Cancer			HIV/AIDS		
Kidney/Urinary			Hepatitis		
Osteoporosis			Fractures		
Other			Surgery		

Who do you live with (or intend to live with) at the conclusion of your episode of therapy?

__Live Alone __Spouse/Significant Other __Child/Children __Other Relative __ Personal Care Attendant __Other

Job Description/Social Activities/Recreational activities: (physical tasks, amount of sitting, lifting, computer work etc.):_____

What are your goals for your course of physical therapy? _____

_____

At the present time, would you say your health is excellent, very good, fair, or poor? _____

_____ _____

Patient Signature Date

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CONSENT FORM/RELEASE OF INFORMATION

Patient Name _____

CONSENT TO EVALUATION AND TREATMENT
I do hereby consent to the evaluation and treatment by Pro Motion Physical Therapy. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION
I authorize Pro Motion Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my (Doctor) _____, and (Insurance Company) _____ for communication and care coordination on my behalf. I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis.

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect of copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the rights to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believe it is in you best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper cony of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have you physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14. 2003.**

We arc required by law to maintain the privacy of. and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this forn, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

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CLINIC AND PATIENT FINANCIAL TERMS

Welcome to Pro Motion Physical Therapy, LLC! We are dedicated to providing the best possible physical therapy service and care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. We want to assure that this process is as smooth as possible so that we can focus on our primary concern… your health.

Billing Information

Pro Motion Physical Therapy, LLC does not participate with any insurance companies other than Medicare.

We would like to extendthe courtesy of billing your insurance company for you; however, we do ask that you pay all co-pays, deductibles, and non-covered charges the day of your service.

- We must emphasize, as your physical therapy provider, our relationship is with you and not your insurance company.
- While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the dates the services are rendered. If your insurance company does not pay Pro Motion Physical Therapy within a reasonable period, we will have to look for your payment. We will accept Visa, MasterCard, cash, or check. There is a service fee of $25.00 for al returned checks.
- All insurance plans are not the same and do not over the same services. In the event your insurance plan determines a service to be "not covered", or you do not have the appropriate authorization or referral, you will be responsible for charges on services rendered. You are encouraged to contact your insurance company to verify your benefits and assure that your claims are being processed properly.
- We do not submit claims to third party payers. We will extend the courtesy of submitting claims to your health insurance and it is your responsibility to then file with the third party payer. In the event that your health insurance does not pay, you will be responsible for any remaining balance of payment on your account.
- All past due accounts are subject to collection proceedings. All fees including, but not limited to, collection fees attorney fees, and court fees shall become your responsibility in addition to the balance due to this office. By signing below I am agreeing to be responsible for all cost incurred in the collection of my account.
- All accounts that are 90 days past due will be subject to interest at 1.5 percent.
- ***A $75.00 fee will be charged to your account for appointments cancelled without 24 hour prior notice.***
  This fee is not billable to your insurance company and is your responsibility. We appreciate your respect for other patients who can utilize your reserved time.

Appointment Information

- Your insurance company may require a referral by a physician. This referral should be provided to us on your initial (evaluation) visit to our clinic.
- It is also your responsibility to monitor the number of authorized visits for physical therapy. Frequently, an insurance company will deny payment if the referral is not current or the authorized visits have been exceeded.
- The initial visit will usually last 60 minutes with all subsequent sessions lasting approximately 45-60 minutes.
- Please arrive promptly for each scheduled appointment. Your therapist may be prevented from providing a full treatment if you are more than 15 minutes late.
- Please call at least 24 hours in advance to cancel or change appointment.

Acknowledgement

I have read and understand all of the above information, and agree to abide by all of its terms and conditions. I hereby authorize the release of any information, including medical information, requested by the insurance company for this or any related claim for reimbursement and authorize payment by such insurance company to Pro Motion Physical Therapy, L.L.C. for services rendered. Further, I understand that I am personally responsible for all charges not covered by my insurance company.

Signed_____ Date_____