



## ACE PHYSICAL THERAPY PATIENT REGISTRATION

ALEXANDRIA  ARLINGTON  FAIRFAX  FALLS CHURCH  GREAT FALLS  HERNDON  LEESBURG  TYSONS CORNER

<b>PATIENT INFORMATION</b> (Please Print Clearly)						Date	
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

## **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**

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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 <b>NOT</b> 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**

<i>Insurance Company #1</i>	<i>S.S. # of Insured / ID</i>	<i>Group</i>
<i>and / or</i>		
<i>Insurance Company #2</i>	<i>S.S. # of Insured / ID</i>	<i>Group</i>

**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** \_\_\_\_\_



SIGNATURE OF PATIENT, SUBSCRIBER, GUARDIAN OR BENEFICIARY

**DATE** \_\_\_\_\_

**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 5<sup>th</sup> 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 \_\_\_\_\_



## 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](http://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.

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Patient's Name

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Witness



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Patient/Responsible Party's Signature

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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

(Page 1 of 4)

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

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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain with intercourse, able to complete sex	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain with intercourse prevents any attempt to have sex	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tolerate manual/oral stimulation only -no penetration	<input type="checkbox"/> Yes <input type="checkbox"/> No

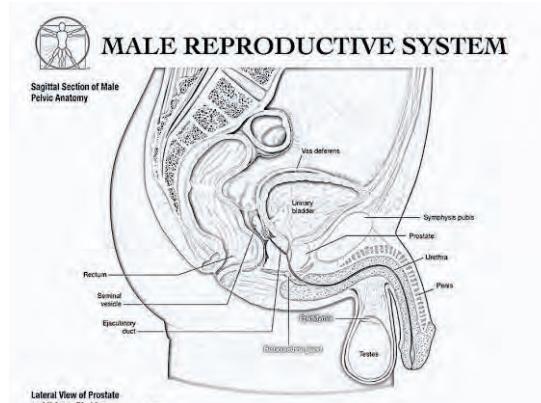
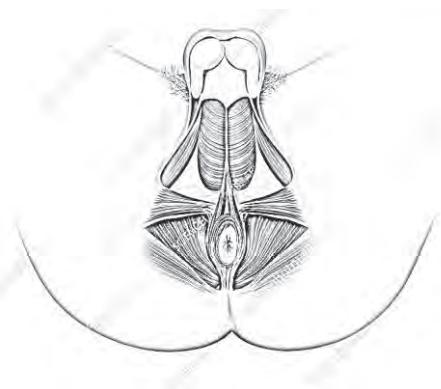
<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Erectile Dysfunction
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shy bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Able to ejaculate
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pelvic/genital pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful Ejaculation
	Other pelvic problems, List-	<input type="checkbox"/> Yes <input type="checkbox"/> 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**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble initiating urine stream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dribbling after urination
<input type="checkbox"/> Yes <input type="checkbox"/> No	Urine intermittent/slow stream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constant urine leakage
<input type="checkbox"/> Yes <input type="checkbox"/> No	Strain or push to empty bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble feeling bladder urge/fullness
<input type="checkbox"/> Yes <input type="checkbox"/> No	Need to urinate with little warning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent bladder infections
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble emptying bladder completely	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful urination
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Volume passed <u>  </u> small <u>  </u> med <u>  </u> 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**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in bowel movement (BM)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble emptying bowel completely
<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful BM	<input type="checkbox"/> Yes <input type="checkbox"/> No	Need to support/splint to complete BM
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble feeling bowel urge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation/straining ____ % of time
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble holding back gas	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current laxative use
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble starting BM	<input type="checkbox"/> Yes <input type="checkbox"/> 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**

<input type="checkbox"/> Refer to attached medication list provided by patient		
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**ALLERGIES:**
**MEDICAL DIAGNOSES AND CONDITIONS** **Please check those *current or past* items that apply to you**

General Health	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problem	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Back Pain
Lungs/Breathing	<input type="checkbox"/> Coughing	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergy	<input type="checkbox"/> Emphysema	<input type="checkbox"/> COPD	<input type="checkbox"/> Smoker (if yes, how many packs per day?)	
Musculoskeletal	<input type="checkbox"/> Back/neck/joint problems	<input type="checkbox"/> Osteoporosis					
Skin	<input type="checkbox"/> Rash	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Open sores	<input type="checkbox"/> Recent tattoos	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Eczema	
Neurological	<input type="checkbox"/> Stroke	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> MS	<input type="checkbox"/> 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: \_\_\_\_\_