



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 <input type="checkbox"/> AM <input type="checkbox"/> 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
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and / or

Insurance Company #2	S.S. # of Insured / ID	Group
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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	<input checked="" type="checkbox"/> _____ 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

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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?	

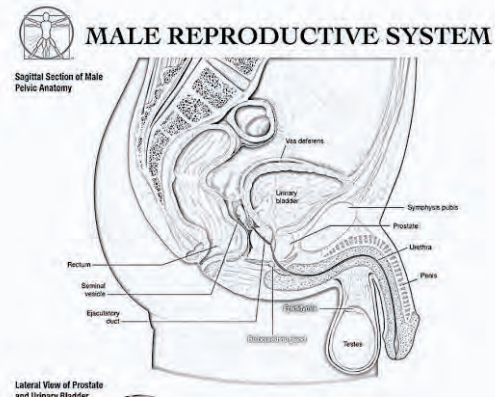
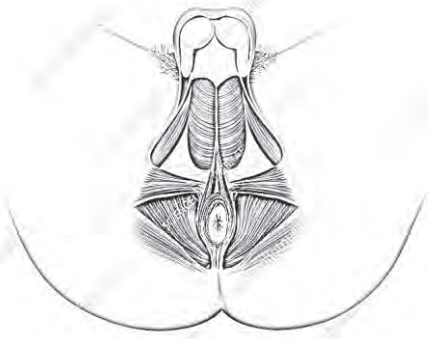
Check ALL the activities that cause or increase your pain:

☐ 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 __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 (1 glass = 8 oz) ____ # glasses/day

Of this total how many glasses are: ☐ Caffeinated? ____ # glasses/day ☐ Fruit drinks? ____ # glasses/day
☐ Alcoholic? ____ # glasses/day ☐ Water? ____ # glasses/day



Ace Physical Therapy Subjective Report/PMHX Form

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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	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: _____