ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITUTE
PATIENT REGISTRATION

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

PATIENT INFORMATION (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

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.

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
131 Elden Street, #308 • 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 & Sports Medicine Institute

ACE Physical Therapy & Sports Medicine Institute, LLC

Subjective Report/PMHX Form

Patient Name: ________________________ **Ht:** ___________________ **Wt:** _______________ **Hand dominance:** ________

E-mail Address: ________________________________ (For office communication only. Will not be disclosed to 3rd party)

What is your chief complaint? ___________________________ **Date of Onset** ________________

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: ____

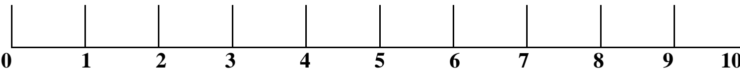
What makes your problem BETTER? ____

What makes your problem WORSE? ____

Pain Rating:

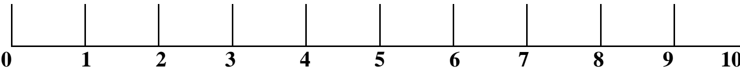
If you have pain, what is your pain level? (0 = No Pain, 10 = Extreme Pain)

Pain Level at WORST: (Circle)



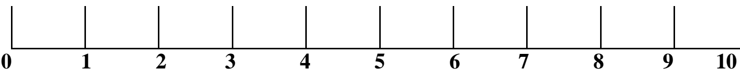
0 1 2 3 4 5 6 7 8 9 10

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) ____

Therapist Comments:

Pain assessment

Fall Risk

Functional Outcome Score

Diagnosis: _____________

Surgical Procedure: _

____

Date of surgery: ________

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 & Sports Medicine Institute
Physical Therapy, Sports, Post-op and Work Rehabilitation

ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITUTE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact the office.
Each time you visit a hospital, physician, physical therapist or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing related information. This notice applies to all of the records of your care generated by the office, whether made by office personnel, medical staff, or your personal doctor.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, medical staff, or other office personnel who are involved in taking care of you at the office. For example: the physical therapist treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

We may also provide your primary healthcare provider, your treating physician or other subsequent health care provider with copies of various reports that should assist him or her in treating you.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the clinical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, and other personnel. And we may combine health information we have to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;
- For conducting training programs or reviewing competence of health care professionals.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include transcription services for our medical records, vendor/technicians for our computer software system. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. **To protect your health information, however, we require the business associate to appropriately safeguard your information.**

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physical Therapists, Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to hospital personnel at local affiliated hospitals as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Military Command Authorities
- Health Oversight Agencies
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to**:

- **Inspect and Obtain a Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed by our Medical Director. We will comply with the outcome of the review.
- **Amend:** If you feel that health information we have about you is incorrect or incomplete, you have the right to request an amendment, for as long as the information is kept by or for the office. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about certain treatment you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. 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.

To exercise any of your rights, please obtain the required forms from our office and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the office and include the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our home office by contacting the main number and asking for the clinic manager. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

MICHAEL ERCOLE, MS, MSPT, FACILITY PRIVACY OFFICIAL
Telephone Number: 703-205-1233