ACE REHAB
PATIENT REGISTRATION

☐ ALEXANDRIA ☐ ARLINGTON ☐ BAILEY'S CROSSROAD ☐ FAIRFAX ☐ FALLS CHURCH ☐ LEESBURG ☐ HERNDON ☐ 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 [] 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.

PATIENT NAME: _____

EMERGENCY INFORMATION *Who should we notify in case of emergency?*

Nearest Relative/Friend *Name*	*Relationship*	*Home Phone*	*Work Phone*

AUTHORIZATION

I, _____, hereby authorize ACE REHAB to apply for benefits on my behalf for covered services rendered by the staff of ACE REHAB.

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 REHAB. 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 REHAB, 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, 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 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 **$25.00 OR $50.00**. Should the therapist deem this treatment necessary, you agree to be responsible for this fee at the time of service. ☑_____/ **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.

ACE REHAB IS A NON-PARTICIPATING HEALTH CARE PROVIDER WHOSE CARE MAY REQUIRE THE PAYMENT OF A HIGHER OUT OF POCKET CO-PAY AND/OR DEDUCTIBLE FROM ME, OR WHOSE CARE MAY NOT BE COVERED BY MY HEALTH INSURANCE.

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 REHAB DATE

ACE Rehab
Physical Therapy, Sports,
Post-op and Work Rehabilitation

Waiver of Health Insurance Benefits

I, _____, the undersigned, do hereby waive health insurance benefits for all treatment and care arising from my injury, which occurred on _____. I am not filing for health insurance benefits or Medicare and waive their responsibility for one or more of the following reasons:

1.) I have not followed my insurance plan's procedure to obtain a referral from my primary care physician to seek services by a participating specialist.

2.) ACE REHAB is a non-participating health care provider whose care may require the payment of a higher out of pocket co-pay and/or deductible from me, or whose care may not be covered by my health insurance.

3.) Because of the nature of my injuries and/or worker's compensation or legal case, I have chosen not to use my health insurance benefits or Medicare to cover any of the health care received as a result of this injury.

I agree and understand that I am accepting responsibility to pay for any services rendered herein. I am instructing my health care provider not to file any claims for benefits with my health insurance plan for treatment relating to or arising from the injuries I sustained in this accident. This decision is being made freely and voluntarily by me, without interference or pressure from others, and is made with the understanding of the responsibilities which arise therefrom.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient/Legal Guardian Name (Printed) Witness

ACE Rehab
Physical Therapy, Sports,
Post-op and Work Rehabilitation

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.acerehab.com, by clicking on the **Privacy** 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: _____

Ace Rehab

Subjective Report/PMHX Form

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?

_____

Therapist Comments:

Pain assessment

Fall Risk

Functional Outcome Score

Diagnosis: _____

Surgical Procedure: _

_____

Date of surgery: _____

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: _____

ACE Rehab
Physical Therapy, Sports,
Post-op and Work Rehabilitation

COVID-19 Pandemic Treatment Consent Form

Patient's Last Name:_____First Name:_____ MI:___

**** We are requesting all patients wear a mask at the time of their visit ****

We have numerous guidelines in place to minimize the risk of transmission. Nonetheless, it is still possible to contract COVID-19 while at a medical office.

I knowingly and willingly consent to have treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious._____(initial)

I understand that due to the frequency of visits of other patients, the characteristics of the COVID-19 virus, and the characteristics of medical procedures, I have an elevated risk of contracting the COVID-19 virus simply by being in a medical office._____(initial)

I confirm that I am not presenting any of these COVID-19 symptoms – fever, shortness of breath, dry cough, runny nose, sore throat._____(initial)

I confirm that I have not been in contact with a person who has been diagnosed with COVID-19 within the past 14 days._____(initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus, and that the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with medical treatment._____(initial)

I verify that I have not traveled outside the United States in the past 14 days._____(initial)

I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days._____(initial)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of any changes in medical status.

Relationship to patient: ☐ Self ☐ Parent

Signature: _____

Date:_____/_____/_____

Ver1.0- 08.2020

2841 Hartland Rd, # 401B • Falls Church, VA 22043
108 Elden Street, #12 • Herndon, VA 20170
19465 Deerfield Ave, #311 • Leesburg, VA 20176

 12011 Lee Jackson Memorial Hwy, #101 • Fairfax, VA 22030

 2877 Duke Street • Alexandria, VA 22314

 8230 Boone Blvd, #202 • Vienna, VA 22182