



## ACE REHAB PATIENT REGISTRATION

☐ ALEXANDRIA ☐ ARLINGTON ☐ FAIRFAX ☐ BAILEY'S CROSSROADS / FALLS CHURCH ☐ FALLS CHURCH/MERIFIELD ☐ HERNDON ☐ LEESBURG ☐ TYSONS

### 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 <input type="checkbox"/> PM <input type="checkbox"/>	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	Name	Relationship	Home Phone	Work Phone
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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



## 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



## 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.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient/Responsible Party's Signature

\_\_\_\_\_  
Date

\*Outside interpreter's name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_



# Ace Rehab Subjective Report/PMHX Form

(Page 1 of 1)

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: \_\_\_\_\_

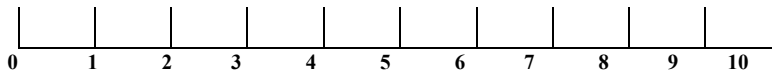
What makes your problem BETTER? \_\_\_\_\_

What makes your problem WORSE? \_\_\_\_\_

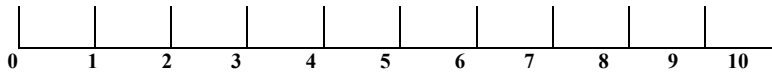
## Pain Rating:

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

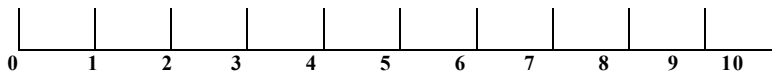
Pain Level at **WORST**: (Circle)



**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: \_\_\_\_\_

## Therapist Comments:

Pain assessment

Fall Risk

Functional Outcome Score

Diagnosis: \_\_\_\_\_

Surgical Procedure: \_\_\_\_\_

Date of surgery: \_\_\_\_\_