225 Reinekers Lane, Ste GR04
Alexandria, VA 22314
Phone: (703)299-3111
Fax: (703)299-1556

SOLUTIONS
Physical Therapy & Sports Medicine

PATIENT & INSURANCE INFORMATION

Patient Name (Last) _____ (First) _____ (MI) _____
Email _____
May we email you appointments reminders, home exercises, and other information about your care? : Y or N

Please list your insurance company name:
Primary: _____ Secondary _____ Tertiary: _____
Have you had physical therapy treatment since January of this year? _____

Address_____City_____ST_____ Zip_____
Home(_____)_____ Work(_____)_____ Cell(_____)_____
Which phone number is the best to reach you at? _____ May we leave you a message? Y or N

Birthdate ____/____/_____ Marital Status _____ Sex M or F

Employer_____ Address_____
Emergency Contact_____ Relation: _____ Phone (_____)_____

Insurance Holder Name (Last)_____(First)_____(MI)____ Birthdate____/____/_____
Insurance Holder Address_____ City/State/Zip_____
Insurance Holder Employer_____ Work Phone(____)_____/_____Relation_____

Symptom Onset or Surgery Date____/____/_____ Body Part_____ Due to Work or Auto?_____
Referring Physician_____ City _____ Phone(_____)_____/_____

**********OFFICE USE ONLY**********

PATIENT Demographics

Name _____
Address _____
DOB _____
Policy Holder _____
Guarantor ? _____
Phone # _____
Email _____
Previous PT? _____

Assigned Therapist _____
Outcome Measure _____

Office Representative _____

INSURANCE Verification

Company _____
Pri/Sec order _____
ID # _____
Group Number _____
Claims Address _____
Payor ID (United) _____
Auth. Req./Entered _____
* Direct Access (30) _____
* Calendar Days (60) _____
* Tricare (10 Visits) _____
* Optum (paperwork) _____
* Doctor or Direct Access _____

SOLUTIONS
Physical Therapy & Sports Medicine

Solutions Physical Therapy & Sports Medicine
Initial Evaluation Questionnaire

Name:_____ **Date of Birth:**_____ **Gender: M F**
Occupation_____ **Primary Care Physician:**_____

How did you hear about us? MD_____ **Friend**_____ **Insurance**_____ **Other:**_____

Have you been out of work due to your injury? Y N *if yes, when did you return to work:*

Please describe your reason for seeking physical therapy? _____

_____

_____

What caused your pain or problem? _____

When did your pain or problem begin? _____

Is your pain getting worse, better, or staying the same? _____

Have you ever experienced this pain or problem before? Y N *if yes, please explain.*

_____

Please rate your pain from 0 – 10 (0 no pain & 10 maximum)_____**/10 @ worst**_____**/10 @ best**

Are you taking any medication for this pain or problem? Y N *if yes, please list*

_____

Does this medication help? Y N *if yes, please explain, or state any comments or concerns regarding this*

_____

Have you had any x-rays, MRI's, or CT scans? Y N *if yes, please explain any known results. If you have a copy of any reports, please provide them.* _____

_____

List any previous musculoskeletal injuries _____

_____

Past Medical History

Condition	*Yes*	*No*	
Diabetes	___	___	
Thyroid Problems	___	___	
Heart Condition	___	___	
Heart Attack	___	___	
Pacemaker	___	___	
Autoimmune Disease	___	___	
Urinary frequency	___	___	
Weight loss/gain > 10lbs	___	___	*(Recent)*
Depression	___	___	
Anxiety	___	___	
Stroke	___	___	
Cancer	___	___	

Are you currently experiencing pain that awakes you from sleep? Y N

Are you pregnant? Y N

Any recent medical (non-orthopedic) surgeries?
Y N *Please list* _____
_____
_____

Other: _____

Are you Allergic to any medications? If so, please list: _____

What are your goals for Physical Therapy?

_____

_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

1) **Uses and Disclosures** Solutions Physical Therapy & Sports Medicine, LLC will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

   Treatment includes the disclosure of health information to other healthcare providers who have referred you to physical therapy or whom you have designated in your Patient Attestation form (Direct Assess clients only). This may include Physician's, Physician Assistants, or Dentist. For instance, we provide your referring Physician with a copy of your physical therapy evaluation or progress notes when you have a follow-up visits with him/her.

   Payment includes the disclosure of health information to your insurance company, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was medically necessary.

   Health Care Operations includes the utilization of your records to monitor the quality of care being given at Solutions Physical Therapy & Sports Medicine.

   Other Special uses may include using your PHI to send you an appointment reminder, or to follow-up with your progress.

   Uses and Disclosures Required by Law

   We may use and disclose your PHI only to an individual or entity that you designate in "HIPAA compliant authorization for the release of patient information" form. We may also disclose your PHI if required by law, for example by a court order or subpoena. In an emergent situation your PHI may be accessed if you cannot speak or act for yourself.

2) **Your Privacy Rights**

   Restrictions: You have the right to request restrictions on how your PHI is used.

   Confidential Communications: You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

   Complaints: If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should have enough information so we can adequately investigate and respond. Solutions Physical Therapy & Sports Medicine is required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. This document serves as our *Notice of Privacy Practices*. We reserve the right to update this notice if required by law.

Solutions Physical Therapy & Sports Medicine, LLC
225 Reinekers Lane, Ste. GR04
Alexandria VA 22314
703-299-3111

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Solutions Physical Therapy & Sports Medicine
225 Reinekers Lane, Ste GR 4
Alexandria, VA 22314

Cancellation Policy

Solutions Physical Therapy & Sports Medicine reserves the right to charge patients for cancelled appointments and No Shows if 24 hours notice is not provided. Our cancellation rate is ***$50*** for a missed appointment. Please understand that we have patients on a waiting list and when given proper notice, we are able to get those patients scheduled in the time slot that you were scheduled for. If we are not given proper notice, those patients will miss out on a potential appointment.

Some patients are signed up for email reminders for their appointments. However, these come from a central server controlled by the electronic medial records company that we subscribe to. Occasionally the email reminders aren't sent or they go to your junk box. Not receiving an email reminder is not a valid reason for not showing up or cancelling your appointment.

Thank you for understanding and assisting us in providing optimal patient care.

_____

Printed Name:

_____

Signature:

_____

Date: