PT Your Way & Advanced Specialty Care
Patient Registration and Authorization Form
Please Print

Today's Date:_____ Diagnosis: _____Date of Birth:_____
Patient Name: First_____ Last_____
Social Security #:_____ Male_____ Female_____ Married___Single___Widowed___
Home Address: _____
City: _____State:_____Zip Code:_____
Phone Numbers: Home: _____ Cell: _____
Work:_____ Email Address:_____
Employer: _____ Occupation: _____

Who can we thank for sending you to PT Your Way? _____
M.D. _____ Friend _____ Insurance Co._____Internet _____ Other_____
Is this treatment related to an auto accident Yes ___ No ____ If YES, Injury Date_____
Have you had any physical/occupational/speech therapy this calendar year? Yes No # of visits_____

Referring Physician: _____ Phone #_____
Primary Care Physician: _____ Phone # _____

Primary Insurance Company:_____
Policy Holder: _____ Policy Holder Date of Birth:_____
Relationship: _____Social Security #_____ Policy Holder Employer: _____

Secondary Insurance Company: _____
Policy Holder: _____Relationship: _____
Policy Holder Date of Birth: _____Social Security #_____

Tertiary Insurance Company: _____Policy Holder:_____
Relationship: _____Policy Holder Date of Birth:_____Social Security #_____

Workman's Compensation Claim # _____Injury Date : _____
Adjuster and Agency_____ Phone # _____

Emergency Contact: _____
Phone # _____Relationship: _____
The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by PT Your Way & Advanced Specialty Care whether or not such services are covered by insurance benefits. The undersigned agrees to reimburse PT Your Way & Advanced Specialty Care for any expenses, including reasonable attorney fees, incurred in connection with the collection of sums due for services performed hereunder.

Patient/Responsible Party Signature: _____ Date: _____

PT Your Way
Patient Health Questionnaire

Date: _____

Patient Name: _____ Height: _____ Weight: _____ Age: _____

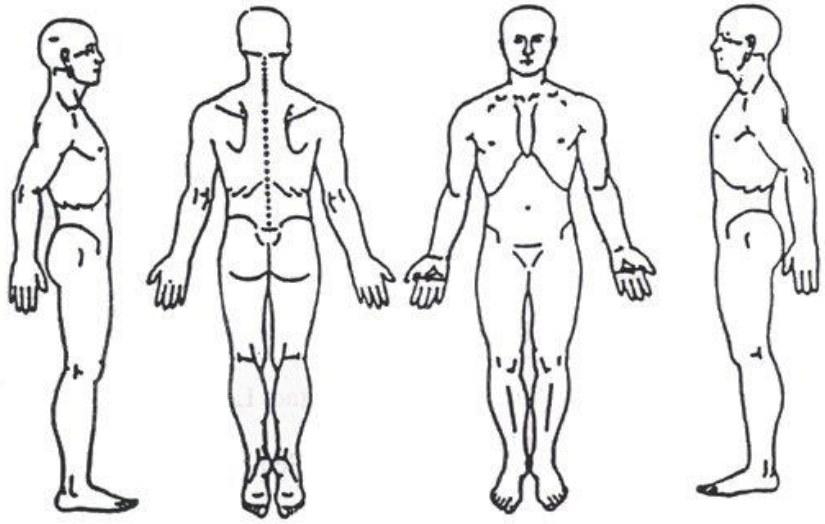
1. Onset of Symptoms/Injury Date_____ Surgery Date (if applicable)_____
2. Describe your symptoms:_____
3. How did your symptoms start or most recently flare-up?_____
   _____
4. During the past week indicate the average intensity of your symptoms on a scale of 0 -10.
   With **0 being NO PAIN** and **10 being UBEARABLE PAIN:** **0 1 2 3 4 5 6 7 8 9 10**

5. During the past week how much has pain interfered with your normal work? (include work outside the house and housework) Please circle:
   Not at all A little bit Moderately Quite a bit Extremely

6. Have your symptoms caused you to stop or limit participation in events such as? please circle**;**
   work church gym recreation other_____
7. How often do you experience your symptoms? Circle: **Constantly Intermittently**

8. What describes the nature of your symptoms? Circle: **Sharp Shooting Stiffness**
   Burning Dull ache Weakness Numb Tingling Off balance

9. How are your symptoms changing? Please Circle **Getting better No Change**
   Getting Worse Fluctuating Unpredictable
10. Have you had similar symptoms in the past? **NO YES If so when_____**
11. Please draw below where you have pain or other symptoms?



Please list your current medications:

_____

_____

_____

_____

_____

_____

_____

12. Who have you seen for your current symptoms? Circle: **Primary Dr. Specialist No One**
Chiropractor Acupuncturist Physical Therapist Masseuse Other_____

13. What tests have you recently had completed for your symptoms?
X-Ray Body part_____ Date_____
MRI Body part_____ Date_____
CT Body part_____ Date_____
Other _____ Date_____

14. What is your current work status? Circle: **Full time Part time Student Retired**
Homemaker Other_____ Occupation (if applicable)_____

15. Are any of the following factors contributing to your current condition? Please circle:
sedentary lifestyle fear avoidance fear of falling vision hearing
memory current home environment alcohol use drugs obesity

16. Please identify up to three important activities that you are unable to do or are having difficulty doing as a result of your current injury or problem. Circle the number on the line that best fits your current ability. **0 being UNABLE TO PERFORM ACTIVITY** and **10 being ABLE TO PERFORM ACTIVITY AT THE SAME LEVEL AS BEFORE INJURY OR PROBLEM.**

		UNABLE										ABLE
1.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Medical History

Please mark Yes or No for each of the following. Any YES answers please explain.

Cardiovascular System:	**Yes**	**No**	**Explain**
Light Headedness		___	___ _____
Heart disease		___	___ _____
Pace Maker		___	___ _____
High Blood Pressure		___	___ _____
Chest paint with rest		___	___ _____
Night sweats		___	___ _____
Shortness of breath		___	___ _____
Excessive sweating		___	___ _____
Heartbeat in abdomen when you lie down		___	___ _____
Leg cramps when walking several blocks		___	___ _____
Pulmonary System:			
Difficulty or labored breathing		___	___ _____
Prolonged cough		___	___ _____
Lung/Asthma		___	___ _____
Smoke/tobacco use		___	___ _____

Blood Born Diseases:	**Yes**	**No**	**Explain**
HIV	___	___	_____
West Nile Virus	___	___	_____
Hepatitis A, B or C	___	___	_____
Lyme's Disease	___	___	_____
Gastrointestinal & Urogenital System:			
Diarrhea or constipation	___	___	_____
Abdominal pain	___	___	_____
Pain or difficulty when urinating	___	___	_____
Leak urine w/cough, sneeze or exercise	___	___	_____
Changes in menstruation pattern (female)	___	___	_____
Currently pregnant	___	___	_____
Endocrine System:			
Unexplained weight loss or gain	___	___	_____
Diabetes	___	___	_____
Thyroid problems	___	___	_____
Easy bruising	___	___	_____
Nervous System/Musculoskeletal			
Have you fallen with injury and/or fallen 2 or more times in the past year?	___	___	_____
Dizziness	___	___	_____
Gait or balance disturbances	___	___	_____
Neurological problems/stoke	___	___	_____
Abnormal Numbness, pins, needles	___	___	_____
Muscle weakness	___	___	_____
Headaches	___	___	_____
Changes in vision	___	___	_____
Arthritis /Joint problems	___	___	_____
Night pain	___	___	_____
Trauma	___	___	_____
Morning stiffness	___	___	_____
Prolonged use of corticosteroids	___	___	_____
Integumentary System:			
Changes in skin color or nail integrity	___	___	_____
General:			
Cancer	___	___	_____
Surgeries	___	___	_____
Fever/Chills	___	___	_____
Unusual swelling/edema	___	___	_____
Other medical conditions	___	___	_____

Any additional explanations: _____

_____

Policies and Procedures

Please read and initial each paragraph and sign the last page

Physical Therapy Your Way & Advanced Specialty Care takes the quality of your health care very seriously. Our model enables us to provide the highest level of specialized care possible. Unlike other physical therapy practices, we are proud to offer one-hour individual appointment sessions with a licensed physical therapist who specializes in treating complex conditions. Our patient centered, holistic approach allows exceptional results and a high rate of patient satisfaction.

_____ (initial) Payment Policy: (**Excluding Medicare Patients)**

Our fee is $136 per visit. Please come prepared to make a payment at each visit. We accept cash, check and major credit cards. **We require a credit card to be maintained on file** for charging visit fees, medical supplies, no show and late cancel fees. To avoid the charges being run on the credit card on file you may still pay for patient responsible charges with cash, check or HSA/FSA cards by presenting these at the front desk prior to your treatment. At the end of each treatment session, you will receive an itemized bill that you can submit to your insurance company. Although we are here to assist you with understanding your insurance coverage, any reimbursement from an insurance company is the responsibility of the patient.

_____ (**initial**) **Payment Policy: Medicare Patients**

I hereby agree to pay any and all charges that are not covered by my insurance plan, such as deductible, coinsurance, copayments, medical supplies, no show and late cancel fees. **We require a credit card to be maintained on file** for charging any fees determined to be patient responsibility. You may still pay for patient responsible charges with cash or check prior to your treatment to avoid the charges being run on the credit card on file.

_____ (initial) Cancellation Policy:

Please contact our office at least **24 business hours prior to your scheduled appointment** to notify us of any cancellations. If 24-hour notification is not given, you will be charged **$60** for the missed appointment. This amount will be collected directly from your credit card on file. To cancel a *Monday* appointment, please call our office by 4:00 p.m. on *Friday*. If over the weekend you need to cancel a Monday appointment, please leave a message as soon as possible so we can attempt to fill the appointment first thing Monday morning. **If we fill your appointment slot you will not be charged.**

_____ (**initial) No Show Policy:**

If you fail to show up for a scheduled appointment a $60 no show fee will be charged to you. This amount will be collected directly from your credit card on file.

_____ **(initial) Late Policy**:

If you think you will be late for your scheduled appointment please call and inform us. We will try to accommodate you however your treatment session time may be reduced in order to remain on time for the courtesy of the next scheduled patient. **If you are late you will still be charged for your full hour treatment session**. Late charges are not reimbursable by your insurance company. (Not applicable to Medicare patients)

_____ (**initial**) **We do understand that unforeseen matters of sickness or emergencies occur that you cannot control. Unfortunately we still need to charge for these missed appointments.** Thank you for your understanding and cooperation.

_____ **(initial) Appointment Reminders:**

We offer automated reminder phone calls, text messages or emails as a courtesy to our clients, however it is ultimately your responsibility to attend your scheduled appointment. Please be sure that the phone number or email you have provided us is correct in order to receive these reminder messages.

I prefer to receive appointment reminders by:

Please circle one: **Phone Call Email Text Message None**

Please list the appropriate phone number or email: _____

_____ **(initial) Return Check Fee**:

If checks are returned from the bank there will be a **$20** returned check fee assessed to your account. This amount will be collected directly from your credit card on file.

_____ **(initial) HIPAA**: I have read and understand I have rights to a copy of Physical Therapy

Your Way's HIPAA privacy notice. I have the right to request restrictions on the use of my information and to revoke my consent at a later date.

Thank you for trusting us with your specialized physical therapy needs. I have read and fully understand the above policies and procedures of Physical Therapy Your Way P.L.C. and agree to these terms.

Signature of Patient/Responsible Party: _____

Date: _____

HIPAA Notice of Privacy Practices
PT Your Way P.L.C.

9447B Lorton Market Street Suite 250
Lorton, VA 22079
PH (703) 372 5716
Fax (703) 372 5718

5695 King Centre Drive
Suite 102
Alexandria, VA 22315
PH (703) 924 2650
Fax (703) 924 2653

This Notice of Privacy Practice Describes how we may use and disclose your protected health information (PHI) to carry out our treatment, payment or health care operations and for other purpose that are permitted or required by the law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you, and that relates to your past, present or future physical or mental health or condition and related health care services. The privacy of your medical information is important to us.

We understand that your medical information is personal and we are committed to protecting it. The record we create of the care and services you receive is needed so we may provide you with the best quality care and also comply with certain legal requirements.

Uses and Disclosures of Protected Health Information

We will use and disclose elements of your protect health information without your signed authorization for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physical therapist's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care with a third party. For example we would disclose your protected health information, as necessary, to another physical therapist's involved in your care or to your referring physician to ensure that the physician has the necessary information to reevaluate, diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for continued physical therapy treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Healthcare operations: We may use or disclose as- needed, your protected health information in order to support the business activities of your physical therapist practice. These activities include, but are not limited to, quality assessment activities employee reviews activities, training of physical therapy students licensing, and conducting or arranging for other business activities. For example, we may disclose your (PHI) to physical therapy students that see patients at our office. We may call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your (PHI) in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings:
Law Enforcements: Coroners, Funerals Directors, and Organ Donation; Research; Criminal Activity: Military Activity and National Security; Workers' Compensation; Inmates: Required Uses and disclosures: under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to Investigate or determine our compliance with requirements of the section 164.500.

(This notice continues on the back of this page)

Other Permitted and Required uses and Disclosures Will be made Only with Your Consent, Authorization or Opportunity to object unless required by the law

Physicians You May revoke this authorization, at any time in writing, except to the extent that your physician or the Practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of protected health information not be described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physical therapist is not required to agree to restriction that you may request. If the physical therapist believes it is in your best interest to permit use and disclose of your (PHI), it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as proved in this notice.

Complaints
You may complain to us or to the secretary of the Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filling a complaint.

This notice becomes effective on /or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with an HIPPA Compliance Officer in Person or by phone at (703) 372 5716

HIPAA Notice of Privacy Practices
PT Your Way P.L.C.

9447B Lorton Market Street Suite 250
Lorton, VA 22079
PH (703) 372 5716
Fax (703) 372 5718

5695 King Centre Drive
Suite 102
Alexandria, VA 22315
PH (703) 924 2650
Fax (703) 924 2653

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We understand that your medical information is personal and we are committed to protecting it. The record we create of the care and services you receive is needed so we may provide you with the best quality care and also comply with certain legal requirements.

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Law Enforcements: Coroners, Funerals Directors, and Organ Donation; Research; Criminal Activity: Military Activity and National Security; Workers' Compensation; Inmates: Required Uses and disclosures: under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to Investigate or determine our compliance with requirements of the section 164.500.

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