

Physical Therapy Registration

°MALE ° FEMALE ° MR. ° MISS ° MRS °MS

How did you hear about us? Arlington Sun Gazette Washington Post Washington Post Express Washington Woman
 Northern VA Magazine Washingtonian Website _____ Arlington Co. Fair Other _____

We are now offering email confirmation of appointments instead of phone calls. Please check yes or no if you prefer email.
 Yes No

Client Identification- Please Print

Last Name First Middle

Age Date of Birth Street Address Apt. No.

City State Zip Code Social Security Number

Home Phone Business Phone Marital Status SINGLE DIVORCED WIDOWED
 MARRIED SEPERATED

Email Address Referred By

Occupation Employer's Name Address

Emergency Contact Relation Telephone Number

FINANCIAL RESPONSIBILITY-If different than client.

Last Name First Middle Social Security Number

Relationship Address City State Zip

Home Phone Business Phone Employer City State

Co-Insurance Payments Required

If you would like us to keep your credit card on file to process after services are rendered please fill out info below. *This card will be charged for any balance that is 30 days past due or more.

Circle one. VISA MASTERCARD AMERICAN EXPRESS *Credit Card Number:

Expiration Date Billing Address and Zip Code

INSURANCE- Please present your card to the receptionist

Name of insurance Company Address

ID/Subscriber/Policy Number Group Number Policyholders Name

If this visit is due to an accident (ex: car, sports, fall etc...) please fill out the following:

Type of accident Date of Injury

I consent to treatment necessary for the care of the above named client.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of my medical records, if necessary.

I acknowledge full financial responsibility for services rendered by Body Dynamics Inc and their professional staff,

and authorize transfer of all unpaid amounts to my Visa/MasterCard/Amex after 120 days from the date of service.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I further authorize and request that insurance payments be made directly to Body Dynamics Inc. should they elect to receive such payment.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date

Signature

Office Policies

We are dedicated to providing highly individualized care for patients with orthopaedic injuries. Insurance companies will not dictate the care you receive at BDI. Your plan of care is achieved through the professional assessment of your therapist and physician, and is based on your specific functional goals. Please read the following policies and sign below.

1. Insurance: In order to maintain our high standard of care, BDI does not participate with insurance plans. Payment is expected when services are rendered. Please make sure that we have all your current insurance information. Courtesy Option-- If insurance was pre-verified by BDI and your credit card information is on file for payment purposes we will submit claim, clients pays the co-insurance and the insurance co. will pay us directly (except Blue Cross Blue Shield, Anthem & MAMSI). This is a courtesy only. Patient is fully responsible for knowing benefit knowledge of his or her own insurance.
2. Worker's Compensation: Worker's Compensation claims will be submitted directly by our office. Please provide us with all the information necessary for billing, including your claim number, date of injury, the name and telephone number of your claim's adjuster, and the correct address to which we should mail the claims.
3. Acupuncture: All services under acupuncture are paid in full at the time of service. We do not bill any insurance for this service.
4. Automobile Accidents: We do not bill your auto insurance nor do we accept assignment on any automobile accident. We do not wait for settlement from attorneys or wait for settlement from any automobile carriers.
5. Medicare: We are not Medicare providers, and cannot bill Medicare for you. At this time we are not accepting Medicare patients.
6. Durable Medical Equipment (DME) and Supplies: DME and supplies are not reimbursable by insurance companies, and must be paid for at the time of your therapy session.
7. Payment: Payment is expected when services are rendered (each visit). For your convenience, we can accept payment on a weekly basis. If alternative arrangements are necessary, please contact us directly. We accept VISA, MasterCard, American Express, Discover, checks and cash. We expect accounts to be paid in full within 30 days from the last day of treatment.
8. Late Charges/Returned Checks: Any account that remains open beyond 30 days from last date of treatment will be subject to a \$10.00 fee for each month that the account is not paid in full. There is a \$35.00 fee for all returned checks.
9. Cancelled/Missed Appointments: If a patient is more than 15 minutes late for an appointment, we reserve the right to reschedule. Late arrivals are subject to the full fee for the session. We require 24-hour notice for cancellations. Appointments that are cancelled with less than 24 hours notice or no show appointments are subject to a \$85.00 charge, which is not reimbursable by insurance companies. Also, if a patient late cancels or no shows more than three times the patient is responsible for the full charge of the visit.
10. Right to Triage: BDI will make every endeavor to see you at your convenience. However BDI reserves the right to triage clients on emergency cases. You may have to be seen by another therapist to be treated when an emergency arises at BDI. This is our team approach to treatment.
11. Fees: As our fees are subject to change without notice, please see our latest fee schedule for Initial Evaluations and subsequent therapy sessions. After the initial evaluation, subsequent physical therapy sessions are billed in 15-minute increments and are typically one (1) hour. The therapist reserves the right to treat the patient for a 50-minute treatment session leaving 10 minutes for the necessary paperwork and documentation for the visit.
12. Consent for Treatment: The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures as requested by the physician prescribing care. Even though your doctor has referred you to therapy for a certain number of visits or length of time, the therapist will monitor your progress and adjust your treatment accordingly.
13. Professional Services Fee: Based on experience and credentials, senior Physical Therapists have an additional fee on top of base rates. This fee cannot be processed with insurance. Rates are subject to change.
14. Our Pledge Regarding Medical Information: We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at BDI. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by BDI. We are required by law to:
 - Make sure that medical information that identifies you is kept private.
 - Give you this notice of our legal duties and privacy practices with respect to medical information about you.

I have read the above policies and understand that payment is due when services are rendered. I agree to accept full financial responsibility for medical expenses incurred at BDI.

If patient is under 18 years of age, and a parent is not able to attend sessions of physical therapy with the minor, the parent(s) signature for authorization allows BDI to commence physical therapy treatments with the patient who is a minor. The parent(s) is also accepting full financial responsibility for the treatment.

Patient's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____
(If patient is under 18 years)

This notice describes how medical 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 our Privacy Contact, Mario Gamboa.

1. Uses and Disclosures of Protected Health Information.

BDI will use or disclose your protected health information (PHI) as described in this section. Your PHI may be used and disclosed by BDI, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of BDI. Following are examples of the types of uses and disclosures your PHI that BDI is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This may include doctors, nurses, technicians, other physical therapists, or other providers who have referred you for services or are involved in your care. For example, we may feel that a patient we are treating for chronic low back pain would benefit from an evaluation by a pain specialist to address pharmacological pain management. The health information we share with the pain specialist would be considered a treatment related disclosure.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include the disclosure of health information to your insurance company, including Medicare and Medicaid, for certain activities before it approves or pays for the health care services recommended, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Health Care Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of BDI. These activities include, but are not limited to, quality assessment activities, employee review activities, training of clinical students and staff, licensing, marketing, and conducting or arranging for other business activities.

For example, we may disclose your PHI to physical therapy students treating patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use your name and PHI for patient flow tracking in the office. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment. We will share your PHI with third party business associates that perform various activities such as billing and transcription.

Other Special Uses: BDI may use your PHI to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law:

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if you are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2. Your Privacy Rights

Following is a description of your rights with respect to your PHI and a brief explanation of how you may exercise these rights.

Restrictions: You have the right to request restrictions on how your PHI is used. However, we are not required to agree with your request. If we do agree, we must abide by your request.

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

Access to PHI: You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing. Any requests that your medical record be sent to a third party of your choosing must also be made through a written request that clearly identifies the relevant third party and grants express permission to release records to that third party.

Amendments: You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures: After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

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 contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy: We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us. You may view the most recent version of our Notice of Privacy Practices at www.bodydynamicsinc.com.

Privacy Contact: If you would like more information about our privacy practices or to file a complaint you may contact:

Name: Mario R. Gamboa, Vice President of Operations
Address: 5130 Wilson Blvd., Suite B-1
Arlington, VA 22205
mgamboa@bodydynamicsinc.com
(703) 527-9557

Effective Date: This Notice will take effect on April 14, 2003

I have reviewed and understand the Notice of Privacy Practices for Body Dynamics, Inc.

Client Signature: _____ Date: _____

Body Dynamics Financial Policy

In order to maintain our high standard of care and individualized treatment sessions, Body Dynamics (BDI) does not participate with any insurance plans. However, BDI is an out-of-network provider for most insurance plans. At this time we do not accept Medicare patients.

Our Pledge

- Your plan of care will be based on the professional assessment of your physical therapist and physician.
- Insurance companies will not dictate the care you receive.
- Functional goals will be established to meet your specific needs and not industry minimums set by insurance companies.

Billing

- Payment is expected when services are rendered.
- The patient is responsible for all charges for services provided by Body Dynamics.

Courtesy Option*

If insurance was pre-verified* by BDI and your credit card information is on file for payment purposes, BDI will submit claims on the patient's behalf. The patient pays the co-insurance at the time of visit and the insurance co. will pay us directly. Any charges not covered by the insurance company are the responsibility of the patient.

* Verification is not a guarantee of payment by the insurance company. The patient is responsible for knowing their insurance benefits and coverage.

** This option is not available for Blue Cross Blue Shield, Anthem, MAMSI, Optimum Choice, or TRICARE. These insurance companies reimburse the patient directly. BDI can submit claims for the patient, but the patient is responsible for the full charge at the time of visit.

I have read Body Dynamics' Financial Policy and understand that the patient is ultimately responsible for all charges for services provided by Body Dynamics.

Patient Signature

Date

Full Disclosure/Client Rights

Dear BDI Client:

Body Dynamics, Inc. is dedicated to providing you with the highest quality clinical care for neuromusculoskeletal rehabilitation, health promotion, fitness and wellness. Our goal is to help you achieve and maintain your maximum potential for a vibrant, productive, and healthy lifestyle. To that end, BDI integrates the expertise of a variety of health care professionals, including physical therapists, massage therapists, acupuncturists, personal trainers, athletic trainers, pilates and other fitness instructors, and registered dieticians.

Our Associates have chosen to work together to create a center for excellence for rehabilitation, health promotion, fitness, and wellness. We hold ourselves to the highest standards within our given areas of expertise. BDI supports and creates many in-house opportunities for continued competencies, integration of best practices and latest evidence, and collaboration among staff members. When clients participate in multiple services, we emphasize coordination of care and communication among service providers.

During the course of your care, additional services may be recommended to you. These recommendations will be based on objective findings and/or the clinical expertise of the associate you are seeing. Upon receiving such recommendations, please be advised that you reserve the right to:

1. Decline the recommendations;
2. Accept the recommendations, and request collaboration with your own providers;
3. Accept the recommendations, and request collaboration with BDI's providers.

If at anytime during the course of your care at BDI, you are not achieving your goals – we will immediately re-assess your case, revise your plan of care as necessary, or refer you to another provider outside of Body Dynamics.

We believe that integrated care that is immediately responsive to clients' needs is a vital part of the future of healthcare. We also recognize that you retain the right to choose what services you will receive, where you will receive them, and from whom.

When entering into a service at Body Dynamics, we recognize the inherent trust that you place in us to make appropriate recommendations based on the best available evidence. We pledge to hold that trust inviolate.

If you have any questions, do not hesitate to contact me directly.

Sincerely,

Jennifer M. Gamboa, DPT, OCS, MTC
President/Director of Clinical Services

Client Signature: _____ Date: _____

Primary Care and Referring Doctor Information

In order to maintain the highest quality of care and strong communication with each patient's primary care and referring doctor, please provide any information that might pertain to the patient.

Primary Care Physician

Primary Care Physician Name _____

Name of Practice / Specialty _____

Address _____

Phone Number _____

Fax Number _____

Referring Doctor

Referring Doctor Name _____

Name of Practice / Specialty _____

Address _____

Phone Number _____

Fax Number _____

Other Doctor

Other Doctor Name _____

Name of Practice / Specialty _____

Address _____

Phone Number _____

Fax Number _____

Name: _____ Age: _____ Occupation: _____

MEDICAL HISTORY

General Health (check one): Excellent Good Fair Poor

Have you had any medical problems or hospitalizing in the past year (circle)? Yes No

If "yes", please specify: 1. _____
2. _____
3. _____

Surgical History: Procedure: _____ Date: _____
Procedure: _____ Date: _____

Prescription Medications: _____
Over-the-counter Medications: _____

Tobacco (circle) : Yes No If yes, please specify years: _____
Alcohol (circle): Yes No If yes, please specify: amount/day, week, or month: _____
Caffeine (circle) : Yes No # drinks/day _____

During the past month have you felt down, depressed, or hopeless? Yes No
During the past month, have you lost interest or pleasure in doing things? Yes No
Is this something with which you would like help? Yes No Yes, but not today

PAST INJURY/PROBLEM HISTORY

<u>Date</u>	<u>Injury/Problem</u>	<u>Whom Seen</u>	<u>Treatment</u>	<u>Recovery Time</u>
1.				
2.				
3.				

PRESENT INJURIES/PROBLEMS (IF APPLICABLE):

Date of Injury/Onset: _____ Body Part(s): _____
Mechanism of Injury/Onset: _____
Type of Onset (check one): Gradual Sudden Imaging (circle): Yes No
Symptoms at the time of onset: _____
Current symptoms (aggravate/relieve): _____
Pain Rating: Over past 48 hours (0-10) Now _____ Best _____ Worst _____

PRESENT/PAST MEDICAL CONDITIONS (CIRCLE):

Asthma	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	Hernia	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N
Circulatory Disease	Y	N	Kidney Disease	Y	N
Depression	Y	N	Metal/other implant	Y	N
Diabetes	Y	N	Multiple sclerosis	Y	N
Dizziness	Y	N	Nervous Disorder	Y	N
Eating Disorder	Y	N	Numbness	Y	N
Emphysema	Y	N	Osteoporosis	Y	N
Epilepsy	Y	N	Pregnancy	Y	N
Fainting	Y	N	Stroke	Y	N
Fatigue	Y	N	Thyroid Problems	Y	N
Headaches	Y	N	Tuberculosis	Y	N
Hepatitis	Y	N	Weakness	Y	N
Fever/chills/sweats	Y	N	Bowel dysfunction	Y	N
Unexplained weight change	Y	N	Urinary frequency changes	Y	N
Nausea/vomiting	Y	N	Incontinence	Y	N
Night pain	Y	N	Sexual dysfunction	Y	N
Difficulty breathing	Y	N	Pain with sexual intercourse	Y	N
Blood Clot (DVT)	Y	N	Constipation	Y	N

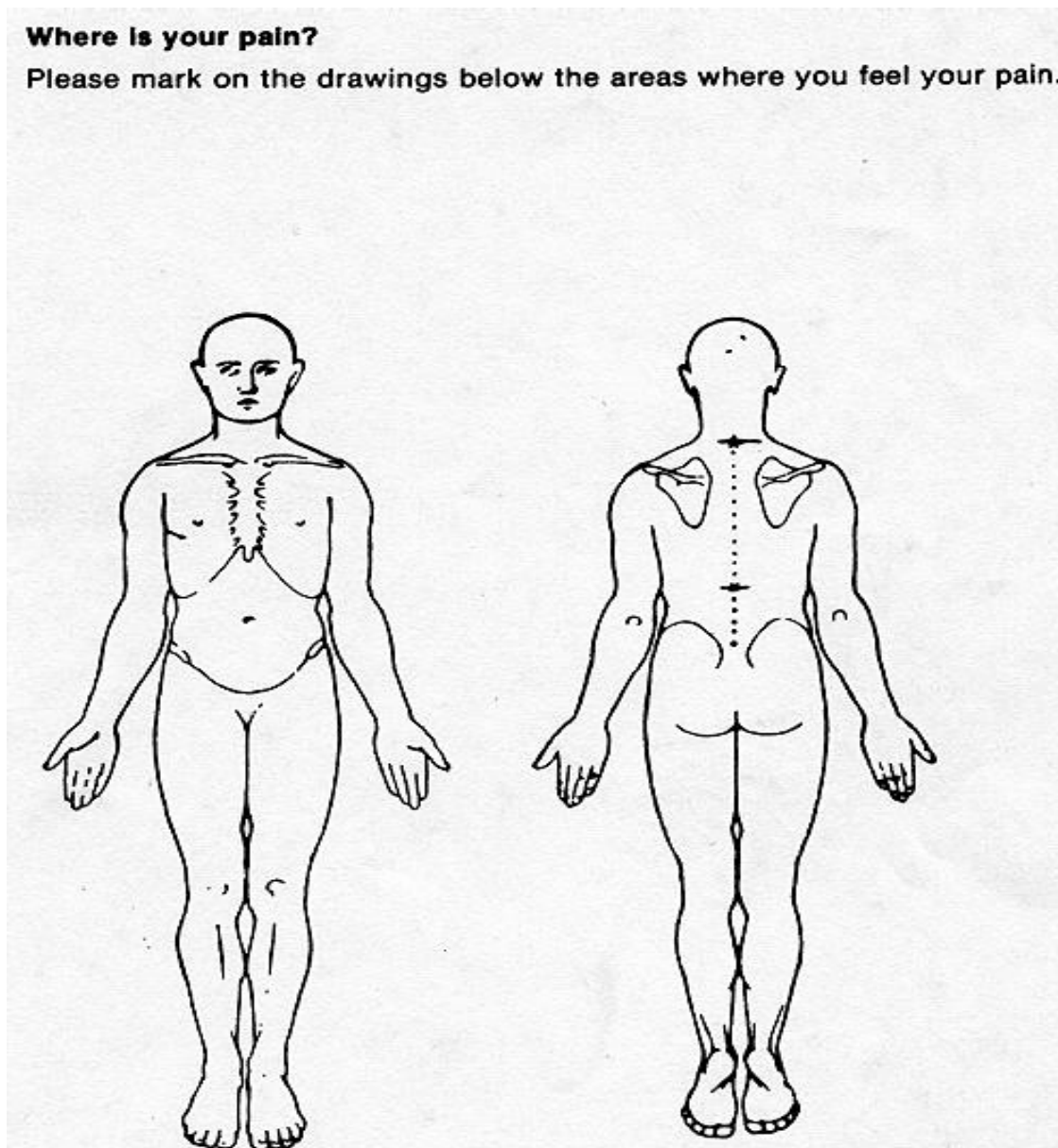
Comments:

Has anyone in your immediate family been treated for any of the conditions listed on the previous page? If yes, please specify:

THE PATIENT-SPECIFIC FUNCTIONAL SCALE¹

Identify up to three important activities that you are unable to do or are having difficulty with as a result of your current injury or condition (pick three (3)). Then score the activity on a 0-10 scale where 0 represents the inability to perform the activity and a 10 represents your ability to perform the activity at the level as before your injury or problem.

	<u>Activity</u>	<u>Score (0-10)</u>
1.		
2.		
3.		



1. Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. *Physiotherapy Canada*, 47, 258-263.