DATE OF EVAL: _____ PT: _____ TO#: _____

PATIENT NAME _____ **DOB**_____SS_____ **SEX:** M / F

MAILING ADDRESS_____ **CITY** _____ **STATE** _____ **ZIP** _____

PRIMARY PHONE _____ Cell / Home **REMINDER** ☐ Call ☐ Text ☐ None Secondary Phone**:** _____Cell / Home

EMAIL _____ **WOULD YOU LIKE TO RECEIVE ELECTRONIC STATEMENTS?** ☐ Yes ☐ No

REASON FOR VISIT_____**INJURY RELATED TO** ☐Work ☐Auto ☐N/A

REFERRING PROVIDER _____ **PRIMARY PROVIDER**_____

EMERGENCY CONTACT_____ **PHONE** _____**RELATIONSHIP**_____

MEDICARE ONLY- Have you had Home Care in the past 60 days? Y / N Agency Name:_____

PRIMARY INSURANCE INFORMATION- PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

PRIMARY INSURANCE_____ **ID** _____**GROUP #** _____

Policy Holder_____ **Relationship**_____ **DOB**_____

Do you have a secondary insurance? ☐ Yes ☐ No (if yes, please make sure that information is listed below)

SECONDARY INSURANCE INFORMATION- PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

SECONDARY INSURANCE_____ **ID** _____**GROUP #** _____

Policy Holder_____ **Relationship**_____ **DOB**_____

WC/AUTO CARRIER_____ **CLAIM #** _____**INJURY DATE / STATE** _____

ADJUSTER NAME_____ **PHONE**_____ **FAX**_____

CASE MANAGER_____ **PHONE**_____ **FAX**_____

Billing Address _____ Claim Open? Y / N

Auth or U/R Required? Y / N U /R PHONE _____ U/R Fax _____

Medical Bill Status _____ Body Part(s) Involved/Injury _____

By signing below, I acknowledge that all of the above information is accurate. I have supplied copies of all of my health insurance cards to the front desk upon registration. I understand that if my health insurance is not on file or I fail to supply the correct insurance information, I may be responsible for all balances. IF at any time any of this information changes, I am aware that I must inform the facility immediately to avoid unnecessary patient balances.

Patient/Guardian Signature: _____ **Date:** _____

03/20
Rev. 10/21

Medical History Questionnaire

Dba Integrated Sports Medicine & Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

Patient Name _____ **Subscriber ID #** _____ **DOB** _____

Are you currently working? ☐ Yes ☐ No ☐ Retired **If Yes, what is your occupation?** _____

Why did you select our facility? ☐ Medical Provider Referral ☐ Returning Patient ☐ Family/Friend ☐ Web/Internet ☐ Workshop/Discovery Visit ☐ Newsletter ☐ Other _____

Describe your current problem and how it began _____

Onset or Surgery Date _____

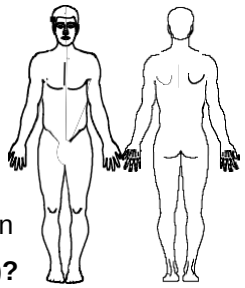
List any diagnostics/tests you have had due to your *current* condition_____

How often are your symptoms present throughout the day?

☐ Constantly (76-100% of the day) ☐ Frequently (51%-75% of the day)

☐ Occasionally (26%-50% of the day) ☐ Intermittently (0%-25% of the day)

Indicate below where you have pain or other symptoms



Describe the nature of your pain ☐ Sharp ☐ Dull Ache ☐ Numbness ☐ Shooting ☐ Burning ☐Tingling

How is your condition changing? ☐Getting Better ☐ Not Changing ☐ Getting Worse

Today's pain level: No Pain **<** 0------1------2------3------4------5------6------7------8------9------10 **>** Unbearable Pain

In the past week, how much has your pain interfered with your daily activities (work, social, household)?

No interference **<** 0------1------2------3------4------5------6------7------8------9------10 **>** Unable to carry out daily activities

Check all that apply ☐ Pain unrelieved by rest ☐ Pain at night ☐ Dizziness/Fainting ☐ Recent Infection/Fever ☐ Fall with or without injury ☐ Pregnant/ # weeks _____

In general, how is your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐Fair ☐ Poor

Who have you seen for your *current* problem before today? ☐ No-One ☐ Doctor ☐ Chiropractor ☐ Physical Therapist

☐ Acupuncturist ☐ Occupational Therapist ☐ Other: _____

>>>If you are a returning patient, your therapist will review your previous medical history with you. Be sure to discuss all changes in your medical condition with them <<<

CONSENT FOR CARE AND TREATMENT

I, the undersigned, give my consent for "Progress" to furnish medical care and treatment considered necessary and proper in diagnosing or treating patient's physical condition.

PRIVACY NOTICE/ HIPAA

A copy of our Privacy Notice was given to you, which describes how your personal medical information will be used or disclosed. PLEASE REVIEW IT CAREFULLY.

HIPAA allows us to speak with family and friends involved in your care. Is there anyone specific you would like us to list by name? _____

Is there anyone that you do **NOT** want us to speak with? _____

CANCELLATION - Kindly provide at least **24-hours** notice if you are unable to keep an appointment so that we may offer that time to another patient. Missed appointment fees may apply if proper notice is not provided.

Patient/Guardian Signature _____ **Date** _____

Printed Name _____ **PT Initial/date** _____

Medical History Questionnaire

Dba Integrated Sports Medicine & Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

FAMILY HISTORY

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following:

- Diabetes
- Heart Disease
- Kidney Disease
- Chemical Dependency (i.e. Alcoholism)
- Ehlers-Danlos Syndrome
- Other
- Cancer
- Inflammatory Arthritis (Rheumatoid, Ankylosing)
- Stroke
- Depression
- Osteoporosis

Please check any of the following that apply to you:

- Pain
- Numbness/Tingling
- Osteoarthritis
- Multiple Sclerosis
- Asthma
- Dizziness/Fainting
- Alcohol/Drug Dependence
- High Blood Pressure
- Circulation Problems
- Osteoporosis
- Epilepsy
- Emphysema/Bronchitis
- Recent Fever
- High Cholesterol
- Blood Clots
- Rheumatoid Arthritis
- Stroke/CVA (Date) _____
- Tuberculosis
- Stomach Ulcers
- Diabetes
- Ehlers-Danlos Syndrome
- Other Arthritic Conditions
- MRSA
- Hepatitis
- Depression

- Cancer If Yes, describe what kind & treatment _____
- Heart Problems If Yes, describe what kind & treatment _____
- Kidney Problems If Yes, describe what kind & treatment _____

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

- Easy Bruising
- Nausea/Vomiting
- Fatigue
- Weakness
- Fever/Chills/Sweats
- Stress at Home or Work
- Tremors
- Seizures
- Double Vision
- Loss of Vision
- Eye Redness
- Joint/Muscle Swelling
- Excessive Bleeding
- Difficulty Breathing
- Regular Cough
- Arm/Leg Swelling
- Heart Racing in your Chest
- Difficulty Swallowing
- Heartburn/Indigestion
- Constipation/Diarrhea
- Blood in Stool
- Blood in Urine
- Skin Rash
- Problems Sleeping
- Sexual Difficulties
- Urinary Incontinence
- Problems Urinating
- Fecal Incontinence

How much caffeinated coffee or other caffeinated beverages do you drink per day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting? _____

Are you now, or have you ever been, a smoker? Yes No If Yes, how many packs of cigarettes do you smoke a day? _____

Have you ever taken an anticoagulant? Yes No

Do you have a pacemaker? Yes No

Have you ever taken steroid medications for any reason? Yes No

During the past month, have you been feeling down, depressed, or hopeless? Yes No

During the past month, have you been bothered by having little interest or pleasure in doing things? Yes No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No

Are you currently pregnant or think you might be pregnant? If Yes, estimated delivery date? Yes No
If Yes, estimated delivery date _____

Medical History Questionnaire

Dba Integrated Sports Medicine & Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

PROCEDURES / SURGERIES: ☐ **NONE** ☐ **BELOW**

DATE	TYPE	DATE	TYPE

CURRENT MEDICATIONS: ☐ **NONE** ☐ **BELOW** ☐ **LIST ATTACHED**

Please list ALL medications that you are **currently** taking **or** attach a copy of your own list. (**Include** prescription, over-the-counter, and vitamin/nutritional supplements). For each medication, list the name, dosage, frequency and route (mouth, inhaler, intravenously, topically, etc).

MEDICATION	DOSE	FREQUENCY	ROUTE

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this provider/practitioner immediately whenever I have changes in my health condition. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed.

Patient/Guardian Signature _____ **Date** _____

Printed Name _____ **PT Initial Review (Date & Initial)** _____

PT Updated (Date & Initial) _____ **PT Updated (Date & Initial)** _____ **PT Updated (Date & Initial)** _____

Dba Integrated Sports Medicine and Physical Therapy, LLC

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Progress Rehabilitation Network, LLC and its Affiliates (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice that sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 5300 Hickory Park Drive, Suite 110, Glen Allen, VA 23059, Attention: Compliance Officer.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

   _____

5. I hereby agree that the Practice may send me confidential communications (e.g. appointment reminders, scheduling changes, responses to my inquiries via:

   PLEASE CHECK ALL THAT APPLY:

   ☐ Home phone/voicemail ☐ Work phone/Voicemail ☐ Mobile phone/voicemail

   ☐ Text Message ☐ Email (Address: _____)

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name (Printed)

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

---

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

___ Accepted ___ Denied ___ Not Applicable _Other (explain) _____

Signature of Authorized Practice Representative _____ Date _____

INTEGRATED
Sports Medicine & Physical Therapy

Dba Integrated Sports Medicine and Physical Therapy, LLC

Cancellation/ No Show Policy

You and your Physical Therapist will develop a treatment plan to maximize your progress in physical therapy in order to help you achieve your goals as efficiently as possible. In order to accomplish your treatment goals, adherence to that plan and your attendance to all scheduled appointments is essential.

We understand that normal life events may sometimes interfere with your treatment plan. If you need to cancel, please call us at least 24 hours before your appointment so that we can reschedule you as needed, and offer your original appointment time to another patient waiting for an appointment. There will be a $50 missed appointment fee for cancelling an appointment with less than 24 hours notice, or for missing an appointment without notice (No Show).

We appreciate your commitment to this process, and your consideration for other patients. If you No Show two (2) appointments, and do not respond to our attempts to contact you, we will interpret that as your decision not to continue therapy. If this occurs, we reserve the right to cancel any a future appointments you may already have on the schedule; and to inform your physician of record that you have discontinued physical therapy.

<u>If you need to cancel or change an appointment, please call us at 703-724-7474 at least 24 hours before your scheduled appointment time.</u>

I have received a copy of this statement and understand this policy.

Patient/Patient's Guardian Signature: _____

Dated: _____

COVID-19 Questionnaire

If you answer YES to Question #1, you may skip Questions #4 and #5, and sign and date at the bottom of this form.

If you answer YES to Questions #2 and/or # 3, PLEASE LET US KNOW IMMEDIATELY!

1) Are you 14 days or more past receiving the final dose of the COVID 19 Vaccine? YES NO

If YES, please provide date of final dose _____ and the type (circle) Pfizer Moderna J&J

Please bring a copy of your vaccine card to your first appointment for us to scan into your chart.

2) Have ***you, a family member or other close contact experienced*** any of the following symptoms or ***been exposed to anyone*** who has had any these symptoms in the past 14 days?

****Fever, chills, generalized muscle aches/pains, cough, sore throat, shortness of breath, loss of smell or taste, new onset of unusual fatigue, headache that is unusual for you, diarrhea, nausea, abdominal pain, acute confusion, hives. *YES NO**

3) Are you currently taking any medications to suppress a fever? *YES NO

4) Have ***you or any close contacts*** had any known exposure to the Corona Virus in the past 14 days?

***YES NO**

5) Are you wearing a mask when in public places and when socializing indoors, and practicing social distancing?

YES *NO

I understand that it is my responsibility to immediately inform dba Integrated Sports Medicine and Physical Therapy, LLC if I develop any of symptoms noted in #2 above; if I have had close contact with anyone else with these symptoms or that has been diagnosed with Corona Virus; or if I have been advised to self-quarantine. I also understand that, if any of my answers have a * next to them, special accommodations may need to be made for my care (e.g. my appointment *may* need to be re-scheduled or virtual visits will be offered) in order to maintain the lowest possible risk of the spread of COVID-19 at our office. I understand that dba Integrated Sports Medicine and Physical Therapy, LLC has a strict policy that all who visit will wear a mask (no valve on mask) that covers their nose and mouth for the entire time visiting our office, even when socially distanced from others.**

Name (Print)_____Signature_____Date _____

ONLY PRINT AND FILL OUT IF YOU HAVE MEDICARE OR A MEDICARE REPLACEMENT PLAN

Integrated Sports Medicine and Physical Therapy, LLC

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name _____
Integrated Sports Medicine and Physical Therapy, LLC Acct # _____

Medicare # (exactly as on Red-White-Blue Government Medicare Card) _____

Please read and respond to each of the following:

1. **Have you had any Home Health Care visits from any Home Health provider in the past 60 days?** Yes or NO

   If yes, please provide the name and phone number of the Home Health Agency:

   Home Health Agency Name: _____

   Home Health Agency Phone Number: _____

2. **Was your illness/injury due to any of the following:** Yes or No If yes, please indicate.

   ☐ Work-Related

   ☐ Automobile Accident

   ☐ Accident on Property (other than your own)
   (Example: store, restaurant, etc.)

3. **If Medicare coverage is due to age or disability, do you have group insurance coverage through another family member's current employer?**

   ☐ Yes – the group insurance will be primary

   ☐ No – Medicare will be primary

4. **Do you have <u>any</u> benefits through TriCare (formerly Champus)?** Yes or No

If you answered yes to questions 2 or 3 there is a second form to be filled out.

Patient's Signature _____ Date _____

Thank You

DIRECT ACCESS PATIENT ATTESTATION AND MEDICAL RELEASE FORM

PATIENT INFORMATION

	Date
Name (Full Legal Name)	**( ) Primary Phone Number**
Street address, City, ST, ZIP Code	**( ) Alternate Phone Number**
Email address	**( ) Alternate Phone Number**

Reason why you are seeking physical therapy care:

CURRENT CARE AND ATTESTATION

Please check one below:

☐ I **AM NOT** under the care of a licensed health practitioner for the symptoms listed on this form and I wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

I understand that the current course of physical therapy care will last no more than 60 consecutive days, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 60-day period, I will be required to obtain a referral from a licensed health care practitioner.

☐ I **AM** under the care of a licensed health practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

PRACTITIONER INFORMATION:

Practitioner Name	**Office Number**
Street address, City, ST, ZIP Code	**Fax Number**

I understand that the current course of physical therapy care will last no more than 60 consecutive days, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 60-day period, I will be required to obtain a referral from the licensed health care practitioner named above.

I understand that the practitioner named above will be provided a copy of my initial evaluation and patient history within 14 days. ***I hereby consent to the release of my personal health and treatment records to the practitioner named above.***

Patient Signature **Date**

For Administrative Use Only - Expiration Date: