

Body Kinetics Rehab, LLC

Physical Therapy

Health Care – Registration Form

(Please PRINT & Complete All Sections)

PATIENT INFORMATION			
Last Name		First Name	
		DOB / / mm dd yy	
		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address		Apt. #	
		SSN	
City		State	
		Zip Code	
		Home Phone No. ()	
		Cell Phone No. ()	
Date of Onset/Problem	Occupation	Employer	Work Phone No ()
May we contact via e-mail to confirm appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, e-mail address: _____			
Primary Care Physician: _____		Referring Physician: _____	
Do you have an attorney for this injury <input type="checkbox"/> Yes <input type="checkbox"/> No		Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	
Attorney's Name: _____		Address: _____	
		Phone No.	
IN CASE OF EMERGENCY			
Name of friend or family <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Other:		Home Phone No.	Alternate Phone No.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to **Body Kinetics Rehab, LLC**. I understand that I am financially responsible for any balance. I also authorize **Body Kinetics Rehab, LLC** or insurance company to release any information required to process my claims.

Patient/Guardian Signature

Date

Body Kinetics Rehab, LLC

Physical Therapy

Consent for Care and Financial Policy

I, the undersigned, do hereby agree and give my consent for **Body Kinetics Rehab, LLC** to furnish medical care and treatment. Which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

BENEFIT OF ASSIGNMENT/RELEASE OF INFORMATION

I _____, the undersigned, hereby assign all medical benefits,

Patient/Guardian Name

i.e.: Medicare, workmen’s comp, and private insurance, and any other health plans to which I am entitled to **Body Kinetics Rehab, LLC**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize **Body Kinetics Rehab, LLC** to release all medical information and records necessary to secure payment for services rendered.

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider for medical coverage as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits. If your medical benefits are not paid within sixty (60) days by the insurance carrier, the balance will be due in full from you.

(Check one)

- I am seeking services from a non-participating health care provider whose care may require the payment of a higher out-of-pocket co-insurance and/or deductible from me, or whose care may not be covered by my health insurance.
- I am a Medicare patient. I understand that Medicare has a Physical Therapy Cap that includes a maximum benefit of allowed charges in a year. After meeting my deductible, Medicare will pay 80% and I am responsible for 20% of the allowable charges. “I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier. I authorized any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services”
- I am a Self Pay Patient. I have chosen not to use my insurance benefits, have no insurance or exhausted my benefit.
- I am a worker’s comp. patient (I understand that I would be liable for any outstanding bills)

All co-insurance percentages paid at time of services are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due. Any amount not covered by the insurance company needs to be made by the patient. Payments for supplies are required at time of service as they are not refundable by the insurance carrier.

If any payments of medical benefits are made directly to you for services rendered by **Body Kinetics Rehab, LLC**, you must promptly remit such payment directly to **Body Kinetics Rehab, LLC**. If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all cost of collection, including courts costs, collection agency fees and/or a reasonable attorney fee.

We request that patients who are unable to keep an appointment contact our office at least 24 business hours prior to the scheduled appointment time since there are usually other clients that could benefit from this treatment slot. If a cancellation and/or missed appointment without notification are made the same day as the appointment and the time cannot otherwise be filled, a \$25.00 charge will apply.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature _____ Date _____

Patient/Guardian

Notice of Privacy Practices

Effective Date 4/4/2005

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

OUR LEGAL DUTY

Body Kinetics Rehab, LLC is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION

Body Kinetics Rehab, LLC uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing tracking, and research studies. In any other situation, **Body Kinetics Rehab, LLC** will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same are for public view. You may request a copy of our Notice of Information Practice at any time. If you have any questions about this notice, please call our Privacy Official at (703) 639-0950.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. **Body Kinetics Rehab, LLC** will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLIANTS

If you are concerned that **Body Kinetics Rehab, LLC** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Body Kinetics Rehab, LLC
ATTN: Jessica K. To

7617 Little River Turnpike
Suite LL 110
Annandale, VA 22003
Tel: (703) 639-0950
Fax: (703) 663-8730
www.BodyKineticsRehab.com

Body Kinetics Rehab, LLC

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Patient Privacy Policy & Procedure Statement

Dear Patient:

Body Kinetics Rehab, LLC maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical records and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at (703) 639-0950.

Body Kinetics Rehab, LLC reserves the right to amend, change, and or/revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Discussion of Treatment/Medical Information

A. If you are accompanied to your physical therapy session(s) is it acceptable to discuss your medical information with the individual(s) present? Yes No

B. Is there any individual, besides your doctor and involved health care practitioners, with whom Body Kinetics Rehab, LLC has permission to discuss your treatment plan/medical information? Please check as appropriate and print the individual's name.

Spouse/Significant Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name _____
Son/Daughter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name _____
Son-in-Law/Dghter-in-law	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name _____
Friend	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name _____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name _____

I have read the Notice of Privacy Practices and/or it has been explained to me. Thank you for choosing our health care facility.

Signature _____ Date _____
Patient/Guardian

Body Kinetics Rehab, LLC

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Past Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. This form is considered part of your medical record.

Do you now have, or have you ever had, any of the following?

	Y	N	When/Where
Asthma, Bronchitis, or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath/Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary Heart Disease or Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack/Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood clot/Emboli	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer/Chemotherapy/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Latex Sensitivity/Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe or frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision or Hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel/Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list all surgeries or other conditions that required hospitalization:

Dates	Reason for Surgery/Hospitalization
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

List all Medication you are taking:

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

Have you recently noticed the following within the last couple of months?

- Yes No Weight loss/gain Yes No Numbness or tingling
 Yes No Fever/Chills/sweats Yes No Nausea/vomiting
 Yes No Fatigue Yes No Weakness

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignments of benefits.

Patient/Guardian Signature

Date

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Video Taping and Photographs Consent Form

(Check all that apply)

I CONSENT AND GIVE PERMISSION to **Body Kinetics Rehab, LLC** to video tape me or my child (if a patient) for educational purposes and to use it as part of my rehabilitation program. I understand that any such video, and all rights associated with them, will belong solely and exclusively to Body Kinetics Rehab.

I CONSENT AND GIVE PERMISSION to **Body Kinetics Rehab, LLC** to photograph me or my child (if a patient) for promotional, marketing or educational purposes. I understand that any such photographs, and all rights associated with them, will belong solely and exclusively to Body Kinetics Rehab.

I have read the above consent and fully understand its content and hereby waive all rights associated with the video tapes and photographs.

Signature _____
(Patient/Guardian)

Date: _____