7617 Little River Turnpike, Suite 110, Annandale, VA 22003 Tel: 703.639.0950, Fax: 703.663.8730
www.bodykineticsrehab.com info@bodykineticsrehab.com

Health Care – Registration Form

Please PRINT & Complete All Sections

I.PATIENT INFORMATION (IF A MINOR PLEASE MAKE SURE TO FILL OUT SECTION II)			
Last Name: First Name:		Date of Birth / / mm dd yyyy	Gender
Street Address Apt. #		Home Phone ( ) -	Relationship Status
City State Zip Code		Mobile Phone ( ) -	Occupation
E-Mail address:		Work Phone ( ) -	Employer
Primary Concern or Issue: Date Began:	Primary Care Physician: Referring Physician:		
Do you have an attorney for this injury? Yes, No	Auto Accident? Yes No		
Attorney Name:	Attorney Phone:		
Attorney Address:			

II.GUARDIAN INFORMATION:	
Last Name: First Name:	Primary Phone ( ) -
Relation to Patient:	Alternate Phone: ( ) -
Street Address Apt. #	
City State Zip Code	

III.EMERGENCY INFORMATION:	
Contact:	Primary Phone: ( ) -
Relation to Patient:	Alternate Phone: ( ) -

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**

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Body Kinetics Rehab

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?

	Yes	No	When/Where
Shortness of Breath / Chest Pain	☐	☐	_____
Asthma, Bronchitis, or Emphysema	☐	☐	_____
Do you smoke?	☐	☐	_____
Coronary Heart Disease or Angina	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Attack / Heart Surgery	☐	☐	_____
Do you have a pacemaker?	☐	☐	_____
Blood Clot(s) / Emboli	☐	☐	_____
Stroke/TIA	☐	☐	_____
Epilepsy/Seizures	☐	☐	_____
Diabetes	☐	☐	_____
Cancer/Chemotherapy/Radiation	☐	☐	_____
Osteoporosis	☐	☐	_____
Bowel/Bladder problems	☐	☐	_____
Severe or frequent headaches	☐	☐	_____
Latex Sensitivity/Allergy	☐	☐	_____
Vision or Hearing difficulty	☐	☐	_____
Are you pregnant?	☐	☐	_____

List all allergies:

_____

_____

Please list all surgeries or other conditions that required hospitalization:

Dates Reason for Surgery/Hospitalization

_____ _____

_____ _____

_____ _____

List all Medication currently taken:

_____

_____

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

_____Weight loss/gain _____Nausea/vomiting

_____Numbness or tingling _____Fatigue

_____Fever/Chills/sweats ____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.

_____ _____

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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 reasonable and necessary in the diagnosing or treating of my/ my child's physical condition. **BENEFIT OF ASSIGNMENT/RELEASE OF INFORMATION**

I_____, the undersigned, hereby assign all medical benefits,
Patient/Guardian Name i.e.: Medicare, workers' compensation, 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 if the above statement does not apply to you)

☐ I am seeking services from a non-participating health care provider whose services may require the payment of a higher out-of-pocket co-insurance and/or deductible from me, or whose services 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 authorize 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. Otherwise there is a cancellation fee of **$50.00**.
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.

_____ _____

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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 Name_____Phone:_____

_____Son/Daughter/ In-Laws Name_____Phone:_____

_____Health Care Aide Name_____Phone:_____

_____Friend Name_____Phone:_____

_____Other Name_____Phone:_____

I have read the Notice of Privacy Practices and/or it has been explained to me.

_____ _____

Patient (Guardian) Signature **Date**

Thank you for choosing our health care facility.

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Videotaping and Photography Consent Form

(Check all that apply.)

⎦ I consent and give permission to **Body Kinetics Rehab, LLC** to video tape or photograph me or my child (if a patient) for educational purposes and to use it as part of my rehabilitation program.

⎦ I consent and give permission to **Body Kinetics Rehab, LLC** to allow Student Interns to observe Physical Therapy services provided to me.

I have read the above consent and fully understand its content and hereby waive all rights associated with the videotaping/photographing/observation.

_____ _____

Patient (Guardian) Signature **Date**

(Check all that apply.)

⎦ **I DO NOT** give consent or permission to **Body Kinetics Rehab, LLC** to videotape or photograph me.

⎦ **I DO NOT** consent and give permission to **Body Kinetics Rehab, LLC** to allow Student Interns to observe Physical Therapy services provided to me.

_____ _____

Patient (Guardian) Signature **Date**