7617 Little River Turnpike, Suite 100, 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/ copayment/coinsurance/deductible. 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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Patient Privacy Policy & Procedure Statement

Dear Patient,

Body Kinetics Rehab, LLC maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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?

Name_____ Relationship_____Phone:_____

SMS messages policy:

- You consent to receive messages from the business
- Any personal info will not be shared with third parties for marketing purposes
- Message frequency (number of messages/month/week/etc., frequency varies, or recurring messages)
- You may reply STOP to opt-out of future messaging
- You may reply HELP for more information
- Message and data rates may apply

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

_____ _____

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Cancellation Policy for PT, OT Speech or ABA Services

We understand that unexpected circumstances may arise, requiring changes to scheduled appointments. To ensure the efficient and effective operation of our practice and to accommodate the needs of all our clients, we have established the following cancellation policy:

1. **Cancellation Notice:** Clients are required to provide at least 24 hours' notice if they need to cancel or reschedule a session. This allows us to reallocate the appointment time to another client who may need services.
2. **Late Cancellation, No-Shows, and/or Late Pickups and Drop-offs:** If a client fails to provide at least 24 hours' notice of cancellation or does not show up for a scheduled session without prior notification, they will be considered a "late cancellation" or "no-show." Additionally, showing up late or being late in picking up your child from the office is against our policy and can hold the same consequences as a late cancellation and no-show.
3. **Fee:** A fee of $50 per session will be charged for PT/OT/SLP sessions and $100 will be charged ABA sessions for late cancellations, no-show appointments, and delays in child pickup and drop-off. This fee is designed to cover the costs associated with the missed session and the time that could have been allocated to another client.
4. **Repeated Cancellations:** Clients who repeatedly cancel appointments with short notice, fail to show up for scheduled sessions, or are habitually late in picking up and dropping off their child may be subject to further action, including termination of services.
5. **At Body Kinetics Rehab, we define repeated cancellations as TWO (2) instances within a 3-month span.**
6. **Communication:** It is essential for clients to communicate any scheduling conflicts or changes as soon as they become aware of them. This allows us to make necessary adjustments to our schedule and ensure continuity of care for all clients.

The cancellation fee can be waived if you are able to reschedule at a different time on the same day or within the same week

By printing your name below, you acknowledge that they have read and understand the cancellation policy outlined above. We appreciate your cooperation and understanding in adhering to these guidelines, as they enable us to provide the highest quality of care to all our clients. If you have any questions or concerns regarding this policy, please do not hesitate to contact us.

_____ _____

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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.
It is our policy to have your credit card information on file for Copayments, co insurances and cancellation fees.
All copayments and coinsurance payments are due prior to the treatment session

Check one

☐ 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 to Body Kinetics Rehab LLC. 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 you paid over your co pay or co insurance as determined by the EOB will be refunded to you by Body Kinetics Rehab LLC. Any amount not covered by the insurance company needs to be paid 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.

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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Videotaping and Photography Consent Form

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/ to note progress and to use it as part of my rehabilitation program.

Yes____ No_____

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

Yes____ No_____

I have read the above consent and fully understand its content

_____ _____

Patient (Guardian) Signature **Date**