

## WELCOME TO INOVA PHYSICAL THERAPY CENTER

### GENERAL INFORMATION

Thank you for coming to Inova Physical Therapy Center for your therapy treatment. We are glad you have chosen our facility for your care and know you will find our staff to be dedicated professionals who pride themselves on providing quality care to all clients.

*TO MAXIMIZE THE EFFECTIVENESS OF YOUR TREATMENT, WE REQUEST YOU TURN OFF THE RINGER ON YOUR CELL PHONE AND AVOID USAGE WHILE IN THE CLINIC.*

Please take some time to familiarize yourself with the policies and procedures of this clinic.

### ATTENDANCE

- ◆ We have found that consistent attendance and taking an active role in treatment is the key to success. We ask that you attend scheduled appointments on time. If you find you will not be able to attend your scheduled appointment, you must notify the office as soon as possible. *(If you must cancel an appointment, please notify the clinic as far in advance as possible, or at least 24 hours in advance of your scheduled appointment. (Please see the cancellation policy)*
- ◆ Therapists will make every effort to treat you at your scheduled appointment time so we ask that you attend all appointments on time. Late arrival may result in a shortened or canceled treatment session.
- ◆ In the event of two absences without notification, we reserve the right to remove you from our active patient caseload. We will notify you via telephone if such action is taken. To resume services, you may be required to obtain a new prescription from your physician if treatment has not been rendered within 30 days from your last appointment.
- ◆ For Workers' Compensation clients, we are obligated to inform your case manager or adjuster whenever a treatment session is missed.

### TREATMENT

- ◆ Services rendered must be covered by a current prescription. In order to bill our patient's insurance company, we recommend that you have a prescription dated within the last 60 days of your appointment.
- ◆ Our staff works with a team approach. After your initial evaluation by a licensed therapist, your treatments may be scheduled with another licensed member of the rehabilitation team who will coordinate your care to help you meet your rehabilitation goals.
- ◆ In order to allow timely communications with your referring physician, we ask that you notify us at least several days prior to your physician appointment. We may forward a progress report to your physician's office, if appropriate.
- ◆ Please wear or bring comfortable clothing and appropriate footwear for your treatment. We encourage flat and/or athletic shoes with a non-skid sole.

### BILLING

- ◆ We have included several items that will help guide you through your insurance benefits and will help limit your out of pocket expense. Please review the Insurance Benefit Questionnaire, Estimate of Therapy Benefits, and Financial Policy.
- ◆ Monthly Patient Statements- Statements are mailed only if the insurance company has charged the patient an amount due. All patient balances must be remitted within 10 days of receiving a statement. You can mail your payment, pay at the therapy office, or pay over the phone by contacting our business office at 703-279-4360.

### COPAYMENTS ARE DUE AT THE TIME OF SERVICE

*We hope your time at our clinic will be beneficial to achieving your treatment goals. Our objectives include assisting you in returning to your highest level of function and providing you with the knowledge to become independent with your care and prevention of re-injury. Your active participation in the clinic and compliance with your home exercise program is critical.*

Please let us know if you have further questions.

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at [www.inova.org](http://www.inova.org). I may request that a copy be mailed to me by calling **703-204-3342**.

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
NAME OF PATIENT OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

**INOVA HEALTH SYSTEM  
ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

CAT #84498 / R032103  
PKGS OF 100

**MR 32-06**

**Ambulatory Authorization for Claims Payment and Reviews**

**1. For Medicare Recipients:**

I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

**2. Assignment and Coordination of Insurance Benefits:**

I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to the Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

**3. Unauthorized, Non-covered, or Out of Plan Services:**

I understand that if my insurance carrier or administrator of benefits does not consider any service rendered a covered service or has not authorized these services, they will not pay and I agree to pay for these services. I also understand and acknowledge that in the case of out of plan/network, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

**4. Authorization to Release Information:**

I hereby authorize Inova to release any information acquired during the course of treatment necessary to process insurance claims and or follow-up for healthcare operations and securing payment for services rendered.

**5. Responsibility for Payment:**

In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

**6. Automobile Accident Patients** - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing; have had the opportunity to ask questions and have them answered and accept the above conditions and terms; **have read the notice regarding assignment of medical expense benefits for automobile accident patients, if applicable**; and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. I understand and agree this document will remain in effect for my present inpatient visit and any future outpatient or physician office visits to Inova, unless specifically rescinded in writing by me.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

**Notice: patients are not required to execute this assignment of benefits form. If you do not execute this form, all charges are your responsibility and due at time of service.**



<input checked="" type="checkbox"/>	<b>STANDING REQUEST</b> By my initials, I request that this form remain effective through my / the patient's current course of treatment.
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**Inova Staff:** A list of disability and special need supports and instructions can be found on the back of this form. At the first opportunity, please complete this form with the patient or companion and have it scanned into the patient's electronic medical record. **Complete one form per person requesting accommodation.**

**Patient or Companion:** If you or any companion assisting in your care have a special need, please indicate below:

Patient's medical condition does not allow completion at this time.

	Patient	Companion/Legal Guardian
Are you deaf or do you have serious difficulty hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have serious difficulty walking or climbing stairs? (5 years old or older)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any other special needs or disability that require services or accommodations during your visit today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have indicated a need above, do you or your companion need services or accommodations related to your identified need(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please describe type of accommodation requested:

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Do you have any special instructions for care providers? If so, please describe below:

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Staff Notes regarding accommodations given: (**Inova Staff:** Please document in detail accommodation(s) requested and services given. Resource suggestions on the back.)

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By my signature below, I hereby certify that: (i) I have been given the opportunity to communicate whether I and/or my companion have a disability or special need requiring accommodation; (ii) I have had the opportunity to communicate my needs to staff as reflected above and that the above selections are true, accurate and complete; (iii) I understand that Inova Health System will use its best efforts to accommodate my requests and that any accommodations provided will be given free of charge; (iv) I have been offered/given a copy of the patient rights brochure which contains information for filing a complaint if I am unsatisfied with my requested accommodations during my visit today.

Signature of Patient/Patient Representative/Companion \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

Print: \_\_\_\_\_

Relationship to Patient:  Self  Parent  Family Member  Friend  Other \_\_\_\_\_

Signature of Employee Witness \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

Print: \_\_\_\_\_

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_ MR# \_\_\_\_\_

**Inova Health System  
Americans with Disabilities Act (ADA)  
Special Needs Assessment**





To ensure you receive a complete and thorough evaluation, please provide us with the important information on the following form. If you do not understand a question leave it blank and your therapist will assist you.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Allergies: List any allergies we should know about including medication allergies: \_\_\_\_\_

Latex Sensitive: YES NO Adhesive Allergy: YES NO

Please check the following healthcare professionals you are currently receiving treatment from:

Medical Doctor (MD) Psychiatrist/Psychologist Chiropractor:
Osteopath Physical Therapist Other:

Have you EVER been diagnosed as having any of the following conditions (please circle)?

- YES NO Cancer YES NO Rheumatoid Arthritis
YES NO Heart/Circulation Problems YES NO Other Arthritic Conditions
YES NO High Blood Pressure YES NO Osteoporosis/Osteopenia
YES NO Chemical Dependency YES NO Hepatitis
YES NO Diabetes YES NO Tuberculosis (TB)
YES NO Multiple Sclerosis YES NO Stroke
YES NO Pacemaker YES NO Epilepsy
YES NO MRSA, VRE, C. Diff, Antibiotic Resistant Organism YES NO HIV
YES NO Shingles YES NO Depression
YES NO Other diagnosis not listed:

For Women: Are you currently pregnant or think you might be pregnant? YES NO

Please list any significant injuries, surgeries or other conditions for which you have been treated (including fracture, dislocations, sprains) and the approximate date of injury:

Table with 2 columns: Date, Injury

Please list any OVER-THE-COUNTER, herbal supplements, and PRESCRIPTION medications you have taken in the last week:

Blank lines for listing medications

Have you recently noted:

- YES NO Unexpected weight gain/loss YES NO Fever/Chills/Sweats
YES NO Nausea/vomiting YES NO Night Pain
YES NO Fatigue YES NO Urinary frequency changes
YES NO Weakness YES NO Bowel dysfunction

At the present time, would you say that your health is? (circle one)

Excellent Very Good Fair Poor

Pain: On average over the past 24 hours, what is the average your pain has been?

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

Pain: LEAST: over the past 24 hours, what is the least your pain has been?

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

Pain: WORST: over the past 24 hours, what is the worst your pain has been?

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

Total: \_\_\_\_\_ / 30 (For Therapist)

How satisfied are you with the current use or function of your injured body part?

0 1 2 3 4 5 6 7 8 9 10
Not Satisfied Very Satisfied

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_



# **Cancellation Policy**

Inova Physical Therapy Center's mission is to provide excellent care to each patient in a timely manner. In order for us to deliver care in the most efficient and effective way, we ask that you inform us if you are unable to attend your scheduled appointment. Your notification allows us to better utilize available appointments for other patients in need of prompt medical care.

If it is necessary to cancel your scheduled appointment, **we require that you call or leave a message at least 24 hours before your appointment time.** Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care.

We reserve the right to charge a **\$35 fee** for any scheduled follow-up (1/2 hour) visit or a **\$50** fee for any scheduled one hour visit that is:

- 1. Cancelled with less than 24 hours notice**
- 2. Missed without calling to cancel (no-show)**
- 3. 15 or more minutes late and the therapist is unable to see you**

You are required to pay the cancellation fee prior to the start of your next scheduled visit. Cancellation fees cannot be billed to insurance.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Regular Attendance is Critical for Optimal Outcomes**