Welcome

Date_____

PATIENT INFORMATION

Patient Name_____

Address _____

City _____State ____ Zip_____

Email _____

Sex ☐ M ☐ F Age__ Birthdate_____

__ Single __ Married __Widowed __ Separated

___Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

City _____ State _____ Zip_____

Employer Phone _____

Whom may we thank for referring you?

_____

Phone Numbers

Home_____ Work_____ Ext__

Cell _____

Best Time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____

Home_____ Work_____

Ext_____

Cell _____

PATIENT CONDITION

Reason for Visit _____

Is this work or auto accident related? _____

When did your symptoms appear? _____

Is this condition getting progressively worse?

(circle) Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain (circle): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain?

_____

Is it constant or does it come and go?

_____

INSURANCE

Name of Insurance _____

Id#:_____

Group#: _____

Phone# _____

Subscriber _____

Relationship to Patient _____

Subscriber's Name _____

Date of Birth _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and sign directly to Capitol Rehab all insurance benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Capitol Rehab to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that if a referral is needed, it is my responsibility to obtain it. I understand that insurance benefits quoted to me as a courtesy, may not be correct and that it is my responsibility for understanding my insurance benefits and is not a guarantee of payment.

Responsible Party

Signature_____

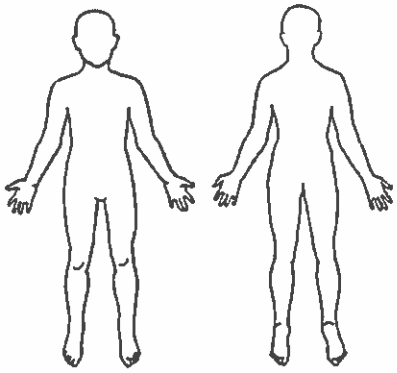
Relationship _____ Date _____

Does it interfere with your: (Circle)

Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: (Circle)

Sitting Standing Walking Bending Lying Down



Capitol REHAB arlington, va

Notice of Privacy Practices (NPP) Policy

At Capitol Rehab, we respect your privacy and the confidentiality of your personal information. In order to safeguard your privacy, we enforce the following privacy principles and information practices as required by the Health Insurance Portability and Accountability Act (**HIPAA**).

We respect your privacy and personal information and will handle your data with care. You have the right to review and correct your personal information. You may review your information and notify us of errors and omissions. We will call all numbers on file and leave a message regarding confirmation of your appointment or with questions regarding your account. If someone calls the office and inquires about you by name, we will give general information (EX: the patient is in the office). We collect and maintain information to administer our business, and to provide products, services, and information of importance to you. We provide security safeguards in the handling and maintenance of your information to protect against risks such as loss, destruction, or misuse. We conduct periodic reviews to ensure proper handling and processing of your information. We do not sell individual information to unaffiliated third parties for marketing purposes. Our information exchanges are within our trusted circle of affiliates and business associates and are designed to deliver products, services, and information that are helpful to you. We require our business associates and affiliates to protect your privacy. We will enforce these principles and hold our business associates and affiliates accountable for protecting your privacy.

I have read the above Notice of Privacy Practices provided to me by Capitol Rehab of Arlington, PLLC.

Signature: _____

Date: _____

If you would like us to contact your Doctor with any updates and reports of your current condition, please provide the following information below.

Doctor's Name: _____

Address: _____

Telephone Number: _____

Capitol REHAB arlington, va

Medical History

Check (V) to indicate if you have had any of the following:

__Allergy Shots	__Cataracts	__High Cholesterol	__Prostate Problem
__Anemia	__Chemical Dependency	__Kidney Disease	__Rheumatoid Arthritis
__Appendicitis	__Diabetes	__Liver Disease	__Stroke
__Arthritis	__Glaucoma	__Migraine Headaches	__Thyroid Problem
__Asthma	__Goiter	__Miscarriage	__Tonsillitis
__Bleeding Disorders	__Gout	__Mononucleosis	__Tuberculosis
__Breast Lump	__Heart Disease	__Multiple Sclerosis	__Tumors/Growths
__Bronchitis	__Hepatitis	__Osteoporosis	__Ulcers
__Cancer	__Hernia	__Pneumonia	__Vaginal Infections

What treatment have you already received for your condition?

__ Medications	__Physical Therapy	__Surgery
__Chiropractic Services	__None	__Other

Name/address of other doctors who have treated you for your condition _____

Are you pregnant? __ Yes ___No Due Date _____

Injuries/Surgeries you have had: **Date:**

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

Medications/Vitamins _____

Allergies _____

Are you interested in:

_____ **Massage Therapy**

Financial Information

FEES AND PAYMENTS

Our fees are based upon reasonable and customary charges. Fees for an initial visit or a new problem are higher than a routine follow-up visit as more time is required to diagnose and treat a new problem than to continue treatment for an existing one. Capitol Rehab bills for each modality rendered at the time of service. Treatment costs vary depending on the type of treatment deemed medically necessary.

MISSED APPOINTMENT/LESS THAN 24 HOURS NOTICE

A 24-hour notice of cancellation is required. With the exception of illness or emergency, I will incur a $25 service fee/$50 for physical therapy/full price for massage therapy, if I fail to appear for a scheduled appointment.

_____ ***Initial Here***

_____**YES!** Send me a **Mobile Text Reminder** of my appointments!

_____ **Mobile Number** _____ **Mobile Provider (Verizon/AT&T/etc)**

CREDIT CARD ON FILE (*Optional*)

Unless co-payment/co-insurance payment is made at each visit, it is our policy to keep a credit card on file.

My credit card number is as follows (optional):

Credit Card Number: _____ Expiration Date: _____

CCV (3-digits on back) _____

Name on Card: _____

- ☐ I authorize the above credit card to be charged at each visit, for the duration of my treatment plan, until my deductible of $_____ is met.
- ☐ I authorize the above credit card to be charged at each visit for my co-pay/co-insurance in the amount of $_____
- ☐ I am using an HSA or HRA account/card for payment

****Be advised that your credit card will be charged at the end of each month if an outstanding balance is due.**

I understand that my insurance will be billed for services rendered. We will make every attempt to obtain payment from your insurance company. If the insurance company denies the claim(s), I understand that I will be responsible/charged for the full amount due._____ ***Initial***

I understand and accept the above policies.

_____ _____

Signature ***Date***