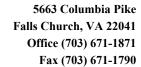




Patient Intake Form

Referring Physician:		Work Related Injui	ry? YesNo
How did you find out a	bout us? □ Direct Mail □ Social Media	☐ Your Physician☐ Family/Friend - V	Who?
	PATIENT INFO	<u>ORMATION</u>	
Legal Name:			
	City:		
	_ Phone Number:		
SSN(required for self pay pa	tients):Pat	ient Employed By:	
	INSURANCE INI		
	EASE AND ASSIGNM		
and/or statement of charge carrier, workman's companyone assisting in obtain Insurance Assignment: insurance, insuring the pto be applied to the charge Agreement to Pay for Statement To Pay for Stat	I hereby assign medical batient or any other party liges for services rendered. Services: For and in considerations of the services is a service of the services of the services.	pervices to, but not limited welfare funds, attornate tenefits of any type arises able for the patients calleration of the care and	ted to, an insurance aleys, consultants, and sing out of any policy of the to, Respire PT LLC, I treatment provided to
patient, including charge the insurance carrier, wo	y Respire PT for all charge es for insurance deductible orkers compensation carrie insultants, and anyone assis	and co-insurance whice r, health and welfare fu	ch are not covered by ands, and fees or
Patient Signature (or legal g	guardian if under 18 years old	Date	





MEDICAL HISTORY

Injury/Condition:		Surg	gery Date:	Onset	Date:
Have you received phys	sical therapy or Ho	ome Hea	lth Care via M	edicare this yea	r? Yes / No
Have you had any in \[\subseteq X-Ray \text{CT S} \] What did they show?	scan		Doppler	\Box Ultrasound	k all that apply: □Bone Scan
Have you recently no	oted:				
= -	□Numbness/Ting	ling [Fatigue	☐ Change InVis	ion or Hearing
□ Nausea/Vomiting	_	_	Headaches	_	
□ Pain at Night					
Do you have now or	have you ever l	nad any	of the follow	ving?	
					\Box Fractures
☐ Heart Problems/Pacer		□Diabete			☐ Blood Pressure Problems
☐Surgeries-list below	<i>I</i>	□Motor	Motor Vehicle Accident		☐ Allergies/Skin Sensitivity
\square Sprains/Strains		□Seizure	es		☐ Hearing Difficulty
☐ Circulation Problems			a/Breathing Pr	oblems	☐Lung Disease
□Stroke		□Leg/Ar	ıkle Swelling		\Box NONE APPLY
\Box Any other medical co	onditions:				
Explain & give approxi	mate dates for any	y items ir	idicated above		
Are you currently tak Attach list - or - Write I Medication:	Name or Type of				
Current Pain Descri Type of Pain: Sharp/Bu Rate your pain (average	rning/Aching/Tin	gling/Nu 10 (1=mi	mbness/Other nimal 10=seve	ere) Pain Level:	0 1 2 3 4 5 6 7 8 9 10
Treatment Goals What do you hope to get Is there anything else you				sical therapist?_	
Patient Signature				Date	



5663 Columbia Pike Falls Church, VA 22041 Office (703) 671-1871 Fax (703) 671-1790

NOTICE OF PRIVACY PRACTICES

(Effective April 14,2003)

AT RESPIRE PT WE PRIDE OURSELVES ON PROVIDING GREAT SERVICE. AS PART OF OUR SERVICE, WE COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA) ACT OF 1996. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. For Payment: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. For Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. For Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law. To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. For Worker's Compensation: We may release medical information about you for workers' compensation or similar programs. For Public Health Risks: We may disclose medical information about you for public health activities. For Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. For Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information if asked to do so by law enforcement officials. For Coroners, Medical Examiners, and Funeral Directors: We may release medical information to a coroner or a medical examiner. For National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. For Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. For Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

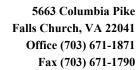
YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. Your Right to an Accounting of Disclosures: You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, as previously described. Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request. Your Right to Request Confidential Communications: You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. Your Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of Department of health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I have been given the Notice of Privacy Practices from I	Respire PT, LLC. I have read and understa	and these practices.
Patient or Personal Representative Signature	- Date	_





MISSED APPOINTMENT AND CANCELLATION POLICY

Respire PT requires 24 hours notice to cancel or reschedule your appointment.

Please call us at least 24 hours in advance to cancel or change a scheduled appointment. Since we reserve an hour on your therapist's schedule for each appointment at Respire PT, we expect you to make every effort to arrive on time and ready for your appointments. Late cancellations and no shows are subject to fees, which are outlined below.

<u>Late Cancellation</u> - Appointment is cancelled within 24 hours of scheduled appointment.

No Show - Patient does not arrive for scheduled appointment or cancels within 2 hours of appointment.

Late Arrival - Patient arrives more than 15 minutes late.

Respire PT collects fees for late cancellations and no shows at the patient's next appointment.

Fees:

- Late cancellations \$50 second incident; \$75 for third incident
- No shows \$75 after second incident

*Illnesses and emergencies are handled on a case by case basis. Please speak with our Office Manager if you have any questions.

Attendance Policy:

The following situations may result in being removed from the therapy schedule and referred back to your doctor:

- Late cancellations (after 3rd incident)
- No shows (after 2nd incident)
- Late arrivals (after 3rd incident)
- Excessive cancellations

be cancelled by Friday.	
email your physical therapist to change or cancel an appointment. Monday appointments need	d to
Cancelling? Please call or email the front desk at least 24 hours in advance to avoid a fee. Do) not

Patient or Personal Representative Signature	Date	