ACCESS PHYSICAL THERAPY, LLC

FAROUK ELKASSED, P.T., DPT
Clinical Director

Patient Information Form

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address 2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Cell provider _____

Date of Birth _____ Gender ____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____
Address _____
Address 2 _____ City _____ State _____ Zip _____

Primary Insurance

Insurance_____ Deductible_____ Subscriber Name _____

ID _____ Max Benefit _____ Relationship_____

Group # _____ CoPay _____ CoInsurance _____ Date of Birth _____

Secondary Insurance

Insurance_____ Deductible_____ Subscriber Name_____

ID_____ Max Benefit _____ Relationship _____

Group # _____ CoPay _____ CoInsurance _____ Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ **Date:** _____

10340 Democracy Lane, Suite 106 • Fairfax, VA 22030 • Phone (703) 865-5538 • Fax (703) 865-5630

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Patient Name_____**Date**_____

1. Date of injury/onset:____/____/_____ **Date of surgery**_____

Check which applies to current condition

_____**Motor Vehicle Accident** _____**Work Related Injury**
_____**Recurrence of previous injury** _____**Others:**_____

2. Do you have or have had any of the following? (Give the date)

	YES	NO	DATE
-Diabetes	____	____	_____
-High Blood Pressure	____	____	_____
-Heart Disease/Attack	____	____	_____
-Cancer; where, when	____	____	_____
-Osteoarthritis	____	____	_____
-Fractures	____	____	_____

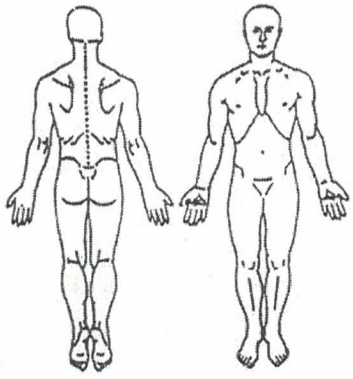
-Others_____

3. Are you taking any medication? ____ ____
If yes, please list what medications and for what condition:_____
_____
_____
_____

4. CONSENT OF TREATMENT

I understand that I have been referred to Access Physical Therapy for treatment. I understand that I have the right to ask any questions regarding my treatment plan. By signing this agreement, I consent to have Access Physical Therapy provide treatment as prescribed by physician and/or recommended by my Physical Therapist.

5. Please indicate below where your symptoms are located:



Signature_____**Date**_____

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CANCELLATION POLICY

THERE WILL BE A **$75.00** CHARGE FOR ALL APPOINTMENTS CANCELLED WITHOUT 24 HOUR NOTICE. THERE WILL ALSO BE A **$75.00** CHARGE FOR ALL NO SHOWS.

NAME (print)_____

SIGNATURE_____

DATE_____

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703-865-5538 office 703-865-5630

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Access Physical Therapy is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

Each time you visit Access Physical Therapy ., a record of your visit is made. Typically, this record contains diagnoses, symptoms, examination, treatment, and a plan or care for subsequent visits. This information serves as your medical record. Your medical record serves as a:

- Means of communication among the many health professionals who contribute to your care.
- Basis for planning your care and treatment.
- Legal documentation describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of information for public health officials charged with improving the health of this state and the nation.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Although your medical record is the physical property of Access Physical Therapy the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information on request.
- Inspect and receive a copy of your medical record.
- Amend your medical record.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include your initial evaluation.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We reserve the right to change our practice and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post it, and if you request, mail you a revised notice.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we receive a written revocation of the authorization according to the procedures included in the authorization.

For more information or to report a problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Farouk Elkassed @ (703) 865-5630

If you believe that your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U. S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S. W.
Room 509F, HHH Building
Washington, DC 20201
Toll Free 1.877.696.6775

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of ACCESS PHYSICAL THERAPY LLC notice of Privacy Practices and that I have read and understood the Notice.

Patient Name (Printed):_____

Parent or Guardian (if applicable):_____

Signature:_____ **Date:**_____

COVID-19
ACTIVE SCREENING QUESTIONNAIRE

This will be updated as the CDC and WA State Health Department's information on COVID-19 continues to change.

Your health and well-being are of the upmost importance and we are taking measures to keep the facility/office a safe environment for employees as well as the individuals under our charge and the public. Therefore, anyone coming into the facility/office will be screened and part of our screening process will include taking their temperature and asking the following questions.

1. Within the last 14-days, have you experienced a new cough that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

2. Within the last 14-days, have you experienced new shortness of breath that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

3. Within the last 14-days, have you experienced a new sore throat that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

4. Within the last 14-days, have you experienced new muscle aches that you cannot attribute to another health condition or a specific activity such as physical exercise?
   - ☐ YES
   - ☐ NO

5. Within the last 14-days, have you had a temperature at or above 100.4° or the sense of having a fever?
   - ☐ YES
   - ☐ NO

6. Within the last 14 days, have you had close contact, without the use of appropriate PPE, with someone who is currently sick with suspected or confirmed COVID-19?* *(Note: Close contact is defined as within 6 feet for more than 10 consecutive minutes)*
   - ☐ YES
   - ☐ NO

If the individual answers YES to any of the questions they will not be allowed into the facility/office unless determined otherwise by a designated DOC medical professional.

**Facilities identified as being at critical staffing levels in health services may have healthcare workers authorized by the HQ Emergency Operations Center to enter the facility under the following guidelines:*

- *As long as they remain asymptomatic;*
- *Self-monitor symptoms as outlined in the guidance; and*
- *Wear a surgical mask at entry and at all times while on facility grounds.*