INOVA®

2PSMHX

Date: ________________

Allergies (include medication allergies): ________________________ Latex Allergy/Sensitivity: ☐ Yes ☐ No

____ Adhesive Allergy/Sensitivity: ☐ Yes ☐ No

Healthcare Professionals from whom you are Currently Receiving Treatment:

☐ Medical Doctor (MD) ☐ Psychiatrist/Psychologist ☐ Chiropractor
☐ Osteopathic Doctor (DO) ☐ Physical Therapist (PT) ☐ Other: ________________________

Have you EVER been diagnosed with any of the following conditions (check all that apply):

Condition	Yes	No	Condition	Yes	No
Anemia	☐	☐	Hypertension	☐	☐
Arthritis - Rheumatoid/Osteoarthritis/Psoriatic	☐	☐	ICD/Pacemaker/Defibrillator	☐	☐
Asthma	☐	☐	MRSA, VRE, C.Diff, Antibiotic Resistant Organism	☐	☐
Cancer (type): (date):	☐	☐	Multiple Sclerosis	☐	☐
Chemical Dependency	☐	☐	Osteoporosis/Osteopenia	☐	☐
COVID-19 (diagnosis date):	☐	☐	Scoliosis	☐	☐
Depression	☐	☐	Seizures	☐	☐
Diabetes Mellitus	☐	☐	Shingles	☐	☐
Emphysema	☐	☐	Smoker (in the past or present)	☐	☐
Headaches/Migraines	☐	☐	Stroke	☐	☐
Heart Disease	☐	☐	Thyroid Disease	☐	☐
Hepatitis	☐	☐	Tuberculosis	☐	☐
HIV/AIDS	☐	☐	Other (indicate):	☐	☐

For Women: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

Surgeries or Other Significant Conditions for which you have been treated (including fracture, dislocations, sprains). Include approximate date of injury.

Injury	Date	Injury	Date

Prescription or Over-the-Counter Medications and Herbal Supplements which you have taken in the last week. Include dose and frequency.

Medication	Dose	Frequency	Medication	Dose	Frequency

Abbreviation Key:
AIDS – Acquired immunodeficiency syndrome
COVID - Corona virus disease 2019
C.Diff – Clostridium difficile
HIV/AIDS – Human immunodeficiency virus
ICD – Implantable cardioverter defibrillator
MRSA – Methicillin–resistant Staphylococcus aureus
VRE – Vancomycin-resistant enterococci

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ________________________

Date of Birth: ________________ Medical Record # ________________

Gender: ❑ Male ❑ Female

Inova Physical Therapy Center
Medical Condition & History

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INOVA

Have you recently noticed any of the following? (check yes or no for each)

Condition	Yes	No	Condition	Yes	No
Bowel Dysfunction	☐	☐	Night Pain	☐	☐
Fatigue	☐	☐	Unexpected Weight Gain/Loss	☐	☐
Fever/Chills/Sweats	☐	☐	Urinary Frequency Changes	☐	☐
Nausea/Vomiting	☐	☐			

At the present time would you say your health is (choose one): ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Have you had any falls in the past year? ☐ Yes ☐ No If yes, how many? ___________ (document when below)

When? ____

____

____

____

Emergency Contact Name: ________________________________ Phone # ____________________________

My signature verifies that the information provided is correct to the best of my knowledge.

Patient or Designated Decision Maker (signature) ________________ Date ____________ Time ____________

If Designated Decision Maker (print name) ________________ Relationship ________________

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ____________________________

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ____________________________

Date of Birth: ________________ Medical Record # ____________________

Gender: ❑ Male ❑ Female

Inova Physical Therapy Center

Medical Condition & History

CAT # 20922DT / R090120 • PKGS OF 50

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. 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

Department/Location: ______________________________

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 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 and acknowledge:

- If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay and I agree to pay for these services.
- **One or more of my physicians may not accept insurance or may be out of network with my health insurance.**
- In the case of out of plan/network physician or services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. 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.

5. 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; and I agree to pay all charges for which I may be legally and/or contractually responsible, including but not limited to health insurance deductibles, co-payments, and non-covered services. **I understand that Inova, its affiliates, agents (including but not limited to debt collectors) or designees may contact me about outstanding balances through various methods including the use of manual representative outbound calls and voice messages and/or automated dialing services and pre-recorded artificial voice messages, at any telephone number I provide to Inova.** 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 outpatient visit and any future outpatient or physician office visits to Inova, unless specifically cancelled in writing by me.* I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Inova.

______________________	______________________	__________	__________
Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

____
Relationship to Patient (if not signed by patient)

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ______________________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

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Date of Birth: ______________ Medical Record # ______________

Gender: ❑ Male ❑ Female

Inova

Authorization for Claims, Payment, and Reviews - Ambulatory

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: ____________ ☐ Other: ____________

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Cancellation Policy

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 appointment.

We reserve the right to charge a $42 fee for any scheduled appointment that is:

1. Cancelled with less than 24-hour notice
2. Missed (no-show) without advanced notice
3. Cancelled due to late arrival (15 minutes or more). A decision to keep the appointment or cancel will be determined in collaboration between the patient and therapist.

You are required to pay the $42 cancellation fee prior to the start of your next scheduled visit. Cancellation fees cannot be billed to insurance.

In the event that you miss two (2) or more appointments, Inova Physical Therapy may place you on a same day schedule for appointments.

If you need to cancel your appointment, please call or leave a message 24 hours in advance. Appointments are in high demand and your cancellation notice will give another person the opportunity to have access to timely care.

Patient Name: ________________________ Date: ____________

Signature: _____________________________