
DIRECT ACCESS PATIENT ATTESTATION AND MEDICAL RELEASE FORM

PATIENT INFORMATION

	<hr/> Date
<hr/> Name (Full Legal Name)	<hr/> ()
	<hr/> Primary Phone Number
<hr/> Street address, City, ST, ZIP Code	<hr/> ()
	<hr/> Alternate Phone Number
<hr/> Email address	<hr/> ()
	<hr/> Alternate Phone Number

Reason why you are seeking physical therapy care:

CURRENT CARE AND ATTESTATION

Please check one below:

- I **AM NOT** under the care of a licensed health practitioner for the symptoms listed on this form and I wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

I understand that the current course of physical therapy care will last no more than 30 consecutive days, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 30-day period, I will be required to obtain a referral from a licensed health care practitioner.

- I **AM** under the care of a licensed health practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

PRACTITIONER INFORMATION:

<hr/> Practitioner Name	<hr/> Office Number
<hr/> Street address, City, ST, ZIP Code	<hr/> Fax Number

I understand that the current course of physical therapy care will last no more than 30 consecutive days, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 30-day period, I will be required to obtain a referral from the licensed health care practitioner named above.

*I understand that the practitioner named above will be provided a copy of my initial evaluation and patient history within 14 days. **I hereby consent to the release of my personal health and treatment records to the practitioner named above.***

<hr/> Patient Signature	<hr/> Date
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For Administrative Use Only - Expiration Date: _____

PATIENT NAME _____ DOB _____ SS _____ SEX: M / F

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY PHONE _____ Cell / Home REMINDER Call Text None Secondary Phone: _____ Cell / Home

EMAIL _____ WOULD YOU LIKE TO RECEIVE ELECTRONIC STATEMENTS? Yes No

REASON FOR VISIT _____ INJURY RELATED TO Work Auto N/A

REFERRING PROVIDER _____ PRIMARY PROVIDER _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

MEDICARE ONLY- Have you had Home Care in the past 60 days? Y / N Agency Name: _____

PRIMARY INSURANCE _____ ID _____ GROUP # _____

Policy Holder _____ Relationship _____ DOB _____

SECONDARY INSURANCE _____ ID _____ GROUP # _____

Policy Holder _____ Relationship _____ DOB _____

WC/AUTO CARRIER _____ CLAIM # _____ INJURY DATE / STATE _____

ADJUSTER NAME _____ PHONE _____ FAX _____

CASE MANAGER _____ PHONE _____ FAX _____

Billing Address _____ Claim Open? Y / N

Auth or U/R Required? Y / N U/R PHONE _____ U/R Fax _____

Medical Bill Status _____ Body Part(s) Involved/Injury _____

Comments _____

By signing below, I acknowledge that all of the above information is true and accurate. IF at any time any of this information changes, I am aware that I must inform the facility immediately to avoid unnecessary patient balances.

Patient/Guardian Signature: _____ Date: _____

INSURANCE VERIFICATION

PRIMARY INSURANCE VERIFICATION

Effective Date _____ Calendar/Contract Year _____ Copay _____ Co-Insurance _____

Deductible _____ Deductible Met _____ OOPMAX _____ OOPMAX MET _____

Visit Limit _____ Visits Used _____ Auth? Y / N _____ PCP Referral? Y / N

PT Eval within 180 days? Y / N Comments _____

Insurance Representative Name _____ Call Reference Number _____ Date Called _____ Staff Initials _____

SECONDARY INSURANCE VERIFICATION

Effective Date _____ Calendar/Contract Year _____ Copay _____ Co-Insurance _____

Deductible _____ Deductible Met _____ OOPMAX _____ OOPMAX MET _____

Visit Limit _____ Visits Used _____ Auth? Y / N _____ PCP Referral? Y / N

PT Eval within 180 days? Y / N Comments _____

Insurance Representative Name _____ Call Reference Number _____ Date Called _____ Staff Initials _____

OFFICE STAFF USE ONLY

Intake Registration Completed By: _____ Date: _____

Front desk representative will check each task below once completed.

- Copies of all insurance cards (front and back) and photo ID RX (if direct access, form given) Patient Intake Form (filled out/signed/dated) Medical History Form VOB Form/Consent & Financial Policy Paper Chart Scanned into TO Receipt of Privacy Notice Cancellation Policy

Patient Name: _____ DOB: _____

We have _____ as your primary insurance and _____ as your secondary insurance.
 Has anything changed since we verified that? YES / NO

As a courtesy, we have verified your insurance coverage and benefits. However, per your insurance company, benefits quoted are not a guarantee of payment.

	Primary Insurance		Secondary Insurance	
BENEFIT YEAR/EFFECTIVE DATE: period when benefits are available.				
COPAY: fixed amount due at each visit.				
DEDUCTIBLE: amount <u>you</u> must pay <u>before</u> your insurance company will begin paying.	<u>Individual</u> Total: Met:	<u>Family</u> Total: Met:	<u>Individual</u> Total: Met:	<u>Family</u> Total: Met:
DEDUCTIBLE DEPOSIT: deposit collected each visit toward your deductible.				
CO-INSURANCE: percentage of covered healthcare cost that you pay.				
OUT OF POCKET MAXIMUM: maximum you pay during your plan benefit year.	<u>Individual</u> Total: Met:	<u>Family</u> Total: Met:	<u>Individual</u> Total: Met:	<u>Family</u> Total: Met:
VISIT OR DOLLAR LIMIT: amount of visits or dollar amount covered within your benefit year.	Total:	Used:	Total:	Used:
COMMENTS:				

FINANCIAL POLICY STATEMENT

- ◆ You are required, and you hereby agree, to pay at time of service any required co-payments and deductibles, as well as charges not covered by insurance, outstanding balances, and delinquent accounts.
- ◆ Once your claims have been processed by your insurance company, the allowed balance assigned to patient responsibility is due in full.
- ◆ **Automatic Payment- When paying by credit card, I understand that the credit card processor, WayStar, Inc. stores my credit card information securely. I hereby authorize this credit card for current balances and final payment once all claims have been processed. If at any time, I want to revoke this authorization, I need to inform the facility in writing.**
- ◆ If Workers Compensation or Auto benefits deny/exhaust, remaining bills are sent to your health insurance or to the patient/guarantor.
- ◆ If you receive any payments made directly from your insurance, you hereby agree to promptly remit the same amount to "Progress".
- ◆ If you pay by check, and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee of \$50 within 30 days of the returned check.
- ◆ I agree that if I fail to make any of the payments in a timely manner, I will be responsible for all costs of collecting monies owed for thirty-three percent (33%) of the total indebtedness incurred by "Progress" which includes but is not limited to collection agency fees, court costs and attorney's fees.
- ◆ I hereby assign medical benefits to include major medical benefits to which I am entitled for these services including Medicare, Medigap, Medicaid, private insurance and third party payers to "Progress".

Patient/Guardian Signature _____ Printed Name _____ Date _____

MINORS ONLY- Guarantor Name _____ Phone _____

Address _____ City/ST/Zip _____

I acknowledge that by signing this document I understand the information and have received a copy of this form.

Medical History Questionnaire

Dba Progress Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

Patient Name _____ Subscriber ID # _____ DOB _____

Are you currently working? Yes No Retired If Yes, what is your occupation? _____

Why did you select our facility? Medical Provider Referral Returning Patient Family/Friend Web/Internet

Workshop/Discovery Visit Newsletter Other _____

Describe your current problem and how it began _____

Onset or Surgery Date _____

List any diagnostics/tests you have had due to your *current* condition _____

How often are your symptoms present throughout the day?

Indicate below where you have pain or other symptoms

Constantly (76-100% of the day) Frequently (51%-75% of the day)

Occasionally (26%-50% of the day) Intermittently (0%-25% of the day)

Describe the nature of your pain Sharp Dull Ache Numbness Shooting Burning Tingling

How is your condition changing? Getting Better Not Changing Getting Worse

Today's pain level: No Pain < 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 > Unbearable Pain

In the past week, how much has your pain interfered with your daily activities (work, social, household)?

No interference < 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 > Unable to carry out daily activities

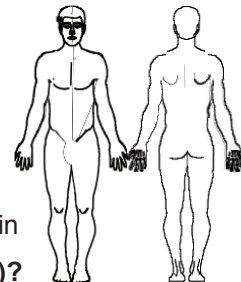
Check all that apply Pain unrelieved by rest Pain at night Dizziness/Fainting Recent Infection/Fever

Fall with or without injury Pregnant/ # weeks _____

In general, how is your overall health? Excellent Very Good Good Fair Poor

Who have you seen for your *current* problem before today? No-One Doctor Chiropractor Physical Therapist

Acupuncturist Occupational Therapist Other: _____



>>>If you are a returning patient, your therapist will review your previous medical history with you. Be sure to discuss all changes in your medical condition with them <<<

CONSENT FOR CARE AND TREATMENT

I, the undersigned, give my consent for "Progress" to furnish medical care and treatment considered necessary and proper in diagnosing or treating patient's physical condition.

PRIVACY NOTICE/ HIPAA

A copy of our Privacy Notice was given to you, which describes how your personal medical information will be used or disclosed. PLEASE REVIEW IT CAREFULLY.

HIPAA allows us to speak with family and friends involved in your care. Is there anyone specific you would like us to list by name? _____

Is there anyone that you do **NOT** want us to speak with? _____

CANCELLATION - Kindly provide at least **24-hours** notice if you are unable to keep an appointment so that we may offer that time to another patient. Missed appointment fees may apply if proper notice is not provided.

Patient/Guardian Signature _____ Date _____

Printed Name _____ PT Initial/date _____

Medical History Questionnaire

Db Progress Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

FAMILY HISTORY

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Inflammatory Arthritis (Rheumatoid, Ankylosing) |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency (i.e. Alcoholism) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ehlers-Danlos Syndrome | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other | |

Please check any of the following that apply to you:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Ehlers-Danlos Syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other Arthritic Conditions |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke/CVA (Date) _____ | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Alcohol/Drug Dependence | | | |
| <input type="checkbox"/> Cancer | If Yes, describe what kind & treatment _____ | | |
| <input type="checkbox"/> Heart Problems | If Yes, describe what kind & treatment _____ | | |
| <input type="checkbox"/> Kidney Problems | If Yes, describe what kind & treatment _____ | | |

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

- | | | |
|---|---|---|
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Joint/Muscle Swelling | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Problems Sleeping |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Regular Cough | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Arm/Leg Swelling | <input type="checkbox"/> Problems Urinating |
| <input type="checkbox"/> Stress at Home or Work | <input type="checkbox"/> Heart Racing in your Chest | <input type="checkbox"/> Fecal Incontinence |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Difficulty Swallowing | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heartburn/Indigestion | |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Constipation/Diarrhea | |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Blood in Stool | |
| <input type="checkbox"/> Eye Redness | <input type="checkbox"/> Blood in Urine | |

How much caffeinated coffee or other caffeinated beverages do you drink per day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting? _____

Are you now, or have you ever been, a smoker? Yes No If Yes, how many packs of cigarettes do you smoke a day? _____

Have you ever taken an anticoagulant? Yes No

Do you have a pacemaker? Yes No

Have you ever taken steroid medications for any reason? Yes No

During the past month, have you been feeling down, depressed, or hopeless? Yes No

During the past month, have you been bothered by having little interest or pleasure in doing things? Yes No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No

Are you currently pregnant or think you might be pregnant? If Yes, estimated delivery date? Yes No

If Yes, estimated delivery date _____

Medical History Questionnaire

Dba Progress Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

PROCEDURES / SURGERIES: NONE BELOW

DATE	TYPE	DATE	TYPE

CURRENT MEDICATIONS: NONE BELOW LIST ATTACHED

Please list ALL medications that you are **currently** taking **or** attach a copy of your own list. (**Include** prescription, over-the-counter, and vitamin/nutritional supplements). For each medication, list the name, dosage, frequency and route (mouth, inhaler, intravenously, topically, etc).

MEDICATION	DOSE	FREQUENCY	ROUTE

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this provider/practitioner immediately whenever I have changes in my health condition. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed.

Patient/Guardian Signature _____ Date _____

Printed Name _____ PT Initial Review (Date & Initial) _____

PT Updated (Date & Initial) _____ PT Updated (Date & Initial) _____ PT Updated (Date & Initial) _____

Db Progress Physical Therapy, LLC

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Progress Rehabilitation Network, LLC and its Affiliates (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice that sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 5300 Hickory Park Drive, Suite 110, Glen Allen, VA 23059, Attention: Compliance Officer.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

5. I hereby agree that the Practice may send me confidential communications (e.g. appointment reminders, scheduling changes, responses to my inquiries via:

PLEASE CHECK ALL THAT APPLY:

- Home phone/voicemail Work phone/Voicemail Mobile phone/voicemail
- Text Message Email (Address: _____)

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Signature of Patient or Representative

Date

Patient's Name (Printed)

Name of Personal Representative (if applicable)

Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

___ Accepted ___ Denied ___ Not Applicable ___ Other (explain) _____

Signature of Authorized Practice Representative _____ Date _____

Travel/Illness History Questionnaire

If any of your answers have an * next to it, PLEASE LET US KNOW IMMEDIATELY!

1. In the past 14 days, have you: *YES NO
- a. traveled internationally or flown domestically?
 - b. traveled to any known COVID hot spots?
 - c. had close contact with a college student who was sent home due to a COVID outbreak?

If you responded yes above, have you self-isolated or quarantined for 14 days? YES *NO

2. Have you had close contact with anyone (*family, close relationships, coworkers, etc.*) who has travelled by air or to any of the COVID hot spots in the past 14 days? *YES NO
3. Have *you OR a family member* experienced any of the following symptoms or have *you OR a family member* been exposed to anyone who has had any these symptoms in the past 14 days?

****Fever, chills, generalized muscle aches/pains, cough, sore throat, shortness of breath, loss of smell or taste, new onset of unusual fatigue, headache that is unusual for you, diarrhea, nausea, abdominal pain, acute confusion, hives, redness in toes.** *YES NO

4. Have you or anyone in your household had any known exposure to the Corona Virus? *YES NO

5. Are you currently taking any medications to suppress a fever? *YES NO

6. Do you, or does anyone in your household work in a hospital, urgent care or primary care physician's office, daycare or in a setting, such as a restaurant or fitness center, where customers typically do not wear masks? *YES NO

7. Are you wearing a mask when out in the public or socializing indoors, practicing social distancing, avoiding gatherings of groups of 10 or more, and attempting to maintain 6 feet of distance between yourself and other people? YES *NO

I understand that it is my responsibility to immediately inform Progress Physical Therapy, LLC if I develop any of symptoms noted above, have had close contact with anyone else with these symptoms or diagnosed with Corona Virus, or if I have been advised to self-quarantine. I also understand that, if any of my answers have a * next to them, special accommodations may be made, my appointment *may* need to be re-scheduled or virtual visits will be offered, *if appropriate* to maintain the lowest possible risk of the spread of COVID at our office. I understand that Progress Physical Therapy, LLC has a strict policy that all who visit will wear a mask (no valve on mask) that covers their nose and mouth for the entire time visiting our office, even when social distanced from others. I will call 804-270-7754 and let Progress Physical Therapy, LLC know if I am unable to follow this policy before arriving at the clinic.**

Name (Print) _____ Signature _____ Date _____



Db a Progress Physical Therapy, LLC

Cancellation/ No Show Policy

You and your Physical Therapist will develop a treatment plan to maximize your progress in physical therapy in order to help you achieve your goals as efficiently as possible. In order to accomplish your treatment goals, adherence to that plan and your attendance to all scheduled appointments is essential.

We understand that normal life events may sometimes interfere with your treatment plan. If you need to cancel, please call us at least 24 hours before your appointment so that we can reschedule you as needed, and offer your original appointment time to another patient waiting for an appointment. There will be a \$50 missed appointment fee for cancelling an appointment with less than 24 hours notice, or for missing an appointment without notice (No Show).

We appreciate your commitment to this process, and your consideration for other patients. If you No Show two (2) appointments, and do not respond to our attempts to contact you, we will interpret that as your decision not to continue therapy. If this occurs, we reserve the right to cancel any a future appointments you may already have on the schedule; and to inform your physician of record that you have discontinued physical therapy.

If you need to cancel or change an appointment, please call us at 804-270-7754 at least 24 hours before your scheduled appointment time.

I have received a copy of this statement and understand this policy.

Patient/Patient's Guardian Signature: _____

Dated: _____

Progress Rehabilitation Network, LLC & Affiliates