Loudoun Sports Therapy Center
21251 Ridgetop Circle, Suite 140, Sterling, VA 20166
Phone - 703-450-4300 Fax - 703-450-5113
www.loudounsportstherapy.com

"Don't let pain limit you. We Care. We Listen. We Get RESULTS!"

Please fill out all forms completely – all information applies to your care.
WE CANNOT INITIATE TREATMENT WITHOUT YOUR FULL COOPERATION

Patient's Last name_____ First name_____ MI_____

Mailing address_____ City_____ State____ Zip_____

Email_____ Marital Status ◯ single ◯ married ◯ divorced ◯ widowed

Home phone _____ Cell_____ Work_____

Birth date ____/____/____ Age_____ Sex (M/F)_____ Social Security #_____

Employment: ◯ full-time ◯ part-time ◯ not currently working ◯ retired ◯ student

Employer Name: _____

Employer Address _____

Emergency Contact & phone _____

*** **If the patient is under age 21**, please fill out the information below:

Guarantor name _____ Phone_____

Address (if different from above) _____

*****Please fully answer the following questions about the reason you are here today*****

Referring physician _____ Location: _____ Phone: _____
(required)

Primary Physician _____ Location: _____ Phone: _____

Is the condition that brought you here today related to: (check all that apply)

☐ Work Injury ☐ Auto Accident ☐ Sport related injury ☐ Surgery ☐ Other _____

Injury/Accident/ Surgery Onset date_____ Date first consulted physician_____

Are you currently being seen by any of the following? (Please check all that apply)

☐ Chiropractor ☐ Osteopath ☐ Occupational therapist ☐ Speech therapist ☐ Physical Therapist

If so, for what reason? _____

Have you been seen by a physical therapist or chiropractor **for any condition** within the last 12 months? ◯ Yes ◯ No

-If yes, where were you seen? _____

-Were you seen for the same condition that brought you here today? ◯ Yes ◯ No

- If no, what were you seen for? _____

Is there now or will there be an attorney involved in this case ◯ Yes ◯ No

Attorney name and address _____

By signing below, I certify that I have answered the above questions truthfully and to the best of my knowledge.

_____ _____ _____

Patient Signature (parent/guardian if under 21) Printed Name Date

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INSURANCE INFORMATION - Please fill out the following information completely

Primary Insurance Company_____ Policy Holder's Name_____

Your relationship to policy holder_____ Policy Holder's Date of Birth_____

Social Security Number_____ Policy Holder's Employer Name_____

Policy Holder Employer's address_____

******LSTC does not accept assignment from a secondary insurance unless Medicare is your primary insurance. We will gladly submit a claim to your secondary insurance but any payment not made by your secondary insurance will be your full responsibility.******

Secondary Insurance Company_____ Policy Holder's Name_____

Your relationship to policy holder_____ Policy Holder's Date of Birth_____

Social Security Number_____ Policy Holder's Employer Name_____

Policy Holder Employer's address_____

MOTOR VEHICLE ACCIDENT PATIENTS

We **DO NOT** accept assignment from or bill an automobile insurance company and we **DO NOT** wait until settlement for payment. In such cases, you may use your personal health insurance, but they reserve the right to deny payment if another insurance company, even an auto insurance company, is responsible for payment. Your health insurance company may also retract payments at any time if another party is found liable for damages. If you choose not to go through your health insurance, you may set up a payment plan with our billing manager or pay in full at the time of each visit. If you choose to pay in full at the time of each treatment, a 20% discount will be offered.

RELEASE OF MEDICAL INFORMATION

Some insurance and workman's compensation companies require progress notes and/or reevaluations to continue treatment or to prove medical necessity for billing purposes. By signing below, you authorize this center to release all medical records required to facilitate the continuation of treatment and/or the collection of payments to these parties only. If a copy of your chart is required for any other reason, you must fill out a separate Release of Medical Information sheet. There may be charges associated with the copying and distribution of records in this case.

CONSENT FOR TREATMENT

Even though your doctor has referred you to therapy for a certain number of visits or duration of treatment, your physical therapist must meet specific insurance requirements that may change the visit duration. Your therapist and our Patient Representative will educate you on your treatment plan, any precautions, and will work with you to determine mutual goals of physical therapy. Your progress and results will be monitored and your treatment and home program will be updated as necessary to achieve optimal functional ability.

By signing below, I give full consent for Loudoun Sports Therapy Center to provide evaluation and therapeutic treatment procedures as prescribed by my physical therapist and physician. I understand that my progress in physical therapy is dependent upon my attending the prescribed appointments and participation in a home exercise program. I have provided Loudoun Sports Therapy Center with correct information regarding my health history and insurance benefits. I authorize Loudoun Sports Therapy to bill my insurance company for services rendered and accept payment from then directly on my behalf.

_____ _____ _____

Patient Signature (Parent/guardian if pt under 18) Patient Name (printed) Date

_____ _____

Parent/Guardian Name (printed) Witness

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HOW WOULD YOU LIKE OUR PATIENT REPRESENTATIVE TO CONTACT YOU?

◯ Phone:_____ (please provide the number to best reach you by)

◯ Email:_____ (please provide an email address that you check at least weekly)

Please tell us how you heard about Loudoun Sports Therapy Center

◯ My physician **specifically recommended Loudoun Sports Therapy Center.**
◯ Insurance participation book / recommended by insurance carrier
◯ Physician gave you a list of local PT practices and we were most convenient
◯ A friend, relative, or neighbor referred you to us - **Name**_____

**** Please give us their name so we can thank them for the referral and send them a small gift****

◯ Phone book listing
◯ Web page information / Internet Search Engine
◯ Other: _____

General Patient Information

- Patients are responsible for providing prescriptions and insurance referrals on the first date of treatment. In order to bill an insurance company we require a "prescription" to initiate treatment and care.

- Insurance claims are filed by our office weekly.

- All Primary Care referrals and authorizations are the patient's responsibility and must be received before treatment can begin. If any additional referrals or authorizations are needed throughout the course of treatment, they are also your responsibility although we are happy to assist you in this action.

- **CHILDREN ARE NOT ALLOWED IN THE TREATMENT AREA**. Any child brought to the facility MUST stay in the waiting room and MUST be supervised by an adult at all times. Children are prohibited in the fitness and treatment area unless they are a patient. We are NOT responsible for supervising children at any time.

SCHEDULING / CANCELLATION POLICY

At Loudoun Sports Therapy Center, we want you to get the most out of your physical therapy visits. Your physical therapist will recommend a specific number of visits per week for your program. We strongly stress the importance of keeping all scheduled appointments to achieve your personal and physical therapy goals.

Please read the following policy to better help us, help you.

Because we care about all of our patients and their progress, we need your help in keeping our office running on schedule.
- Our goal is to provide all patients with quality care in a timely fashion.
- Please show up to your appointment a few minutes early, dressed, and ready to begin your therapy session.
- We understand that traffic is unpredictable and that schedules change.
  - If you are running late, we ask that you call and inform our staff.
  - If you need to reschedule an appointment, please call our office at least 24 hours in advance so we have the ability offer your un-used spot to another patient. We are happy to work with you to find an alternative appointment time that will allow you to continue to reach the results you are looking for.

As we have a regular waiting list of patient's who both need and want our care, we will charge a $50 fee for a patient who does not show up for appointments or cancels with less than 24 hours notice. This will be your responsibility as insurance will not cover a missed visit fee.

By signing below I acknowledge that I have read and understand the information written above to include Loudoun Sports Therapy Center's patient cancellation and scheduling policy. I have been informed of the no-show/cancellation policy and understand that should I incur such a charge, I am responsible for payment.

I accept the terms of this agreement.

Patient Signature (Parent/guardian if pt under 18)	Patient Name (printed)	Date
Parent/Guardian Name (printed)	Witness	

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FINANCIAL POLICY

At Loudoun Sports Therapy Center, our patients' care is our primary concern**. In order to avoid any miscommunication, we would like you to review the following financial policy**. We encourage you to come to us without hesitation regarding any questions or concerns you may have. **Please read each part of this agreement and initial on each of the provided lines**:

___As a courtesy to you, we will verify your insurance benefits and eligibility prior to your evaluation. On the day of your evaluation, our front desk / patient representative will inform you of the benefits information we have received from your insurance company and provide you with a written copy of your benefits. Please be aware, it is your responsibility to verify your own insurance benefits information. We will assume no responsibility for errors made by your insurance carrier and assuring payment is ultimately your responsibility.

___If your insurance company requests further information **from you**, it is **your responsibility** to complete their request immediately. If you do not complete their request and they deny payment, it is your responsibility to pay the billed amount for all denied services.

___If your insurance company denies payment for services because you are beyond your yearly max visits or allowed amount or for not meeting medical necessity, you will be fully responsible for payment for services rendered.

___**If your address, phone, or insurance change during your care, it is your responsibility to immediately inform the billing representative at Loudoun Sports Therapy Center. If you fail to inform us of changes, you will be responsible for the full cost of any uncovered visits.**

___**Payment is expected at the time of service**. Failure to do so could result in a late payment fee for which you are responsible.

___**With the exception of Medicare, we do not accept assignment from secondary insurances.** In the event that you have a secondary insurance we would be happy to file the necessary claim forms for your secondary insurance however any payment not made by your secondary insurance will be your responsibility. For all Medicare patients, the secondary claim is submitted automatically on your behalf.

___If your address changes during care or before you have completed payment on your account it is imperative that you notify us immediately of any changes. This will help you avoid late payment charges and potential court fees.

___**If you do not have health insurance or wish to pay privately for your care, please speak with our billing representative today. We will work with you to set up a payment plan.**

___**We do not wait for lawsuits to settle for payment**. If you are involved in a lawsuit related to your injury, we expect payment at the time of services. We will gladly assist you in setting up a payment plan but full payment is expected.

___There is a $25-$50 charge for returned checks depending upon bank fees.

___If your account becomes inactive (meaning you have not made a payment for 30 days or more), we will add a non-negotiable $25 late fee to your account.

___If your account remains inactive for 60 days, we will apply an additional $50 late fee to your account.

___If your account remains unpaid, either in part or in full, for 90 or more days you will receive a subpoena demanding your appearance in small claims court. There is an additional $125 fee for court costs. These costs will be applied to your account and will be your responsibility.

___**As a courtesy to you, we will set up payment plans if needed**. Please ask to speak to our Billing Representative to set up a payment plan on your account. If you have not set up a payment plan then payment is due either at the time of treatment (For copay and private pay patients) or upon receiving your monthly statement.

By signing below, I acknowledge that I have read and understand Loudoun Sports Therapy Center's financial policy and I agree to the terms there above. I understand that medical insurance claims will be filed on my behalf and by signing below I agree to such billing. I authorize my insurance company to remit payment for therapy services to Loudoun Sports Therapy Center at the address listed on the claims. I also authorize the release to my insurance company any medical information necessary to process my claims for payment. **I understand that if my insurance company denies payment for any reason, I am responsible for payment for services rendered at Loudoun Sports Therapy Center**. I accept all terms of this agreement.

Patient Signature (Parent/guardian if pt under 18)	Patient Name (printed)	Date
Parent/Guardian Name (printed)	Witness	

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LOUDOUN SPORTS THERAPY CENTER - HEALTH INFORMATION PRIVACY PROTECTION ACT

WE ARE COMMITTED TO YOUR PRIVACY - Our practice is dedicated to maintaining the privacy of your individual and identifiable information. During the course of your business with us, it will be necessary for us to share aspects of your care and health insurance with specific parties. Federal law prohibits us from doing this without your consent. We are required by law to maintain the confidentiality (of health insurance information that identifies you) from parties other than yourself and your insurance company. We are also required by law to inform you of the parties who may have access to your medical information. This process may include the collection of such information as: your full legal name, home / mailing address, date of birth, social security number, insurance identification numbers, treatment for other related and previous conditions, etc. Please trust that this information will be treated in the safest of manners and will not be shared or disclosed unless as otherwise noted below. This information is never shared with any party outside our facility without your written consent except as noted below and will only be accessed by our staff in order to facilitate your care and or payment for our services.

WE WILL COLLECT INFORMATION FOR MANY PURPOSES - Each time you visit our practice a record will be maintained of specific information regarding the particulars of that session. This information may include (but is not limited to): medical record maintenance, treatment that was provided, subjective information you provided us regarding your state of being and the state of the condition, assessment information related to the progression of your condition, billing information, communication with insurance companies etc. When communication is made with your insurance company we will also maintain a record of these communications either in your medical record or billing record.

HOW MAY WE USE AND DISCLOSE YOUR HEALTH INFORMATION

FOR TREATMENT: We will collect subjective and objective data about you that will be used for your treatment. As part of your care, we may disclose information about your treatment to your referring provider, your insurance company, or anyone else who is directly connected with the treatment of this condition. This information may be provided in verbal and / or written format. It will only be provided in the event that these parties can identify you with three specific criteria.

FOR PAYMENT - We may disclose information about your treatment and services to bill and collect from you, your insurance company or a third party payer related to your insurance company (i.e.: payment management company or a Health Savings Reimbursement Account). This may involve our disclosing information about past and expected future services that have been or will be provided by our facility for this current condition.

FOR HEALTH CARE OPERATIONS AND PERFORMANCE IMPROVEMENT - We may use information in your record to help us improve your care as well as the care of other individuals with similar conditions. This may also include the training of new staff within our facility. In this case, no specific information regarding your identity will be utilized.

INDIVIDUALS INVOLVED IN YOUR CARE - We may disclose information about you to friends and family members who are involved in your medical care or who help to pay for care. In these cases the information released is restricted to those individuals who provide proof of their ability to obtain said information.

STATE-SPECIFIC REQUIREMENTS - Many states have requirements for reporting including population based activities related to improving health and reducing health care costs.

WHAT ARE YOUR HEALTH INFORMATION RIGHTS

INSPECT AND COPY - You have the right to inspect your medical record and request a copy at any time. By law, we may deny your right to view or copy this record in certain limited circumstances and in such a case would need to supply you a written denial within 7 days of your request. In this event you may submit a formal letter of appeal to the State Board of Medicine and they will assign an independent third party whose decision would be final.

AMEND - If you feel that information that we have about you is incorrect or incomplete, you have the right to ask us to amend the information. Such a request would need to be submitted in writing to our Director of Medical Records and must state the information to be changed and the purpose for making said change. We do have the right to deny this request and would be required to inform you in writing of our decision to not make the requested amendment.

REQUEST RESTRICTIONS - You have the right to request a restriction or limitation on the health information we use or disclose about you. Please keep in mind that such a request may alter or affect your treatment outcomes or financial responsibility as related to this condition. THIS INFORMATION MUST BE NOTED IN THIS SECTION AT THIS TIME. In order for any change in this restriction to occur, a new and overriding HIPPA agreement must be filed with our office.
PLEASE LIST HERE ANY PARTY / PARTIES THAT YOU DO NOT WANT TO HAVE ACCESS TO YOUR MEDICAL RECORD OR INFORMATION:

RECEIVE A PAPER COPY OF THIS NOTICE - You have the right to verbally request a copy of this written notice at any time.

CHANGES TO THIS NOTICE - We reserve the right to change this notice at any time. The revised or changed notice will be effective for the information that we have on hand as well as any information that we receive in the future. The revised notice would be made available to you immediately upon its release and would ultimately be binding over any previous release.

COMPLAINTS - If you believe your privacy rights have been violated you have the following options: (these must be completed in the order listed)
Contact our Medical Records Director immediately either via:
Phone: (703) 450 – 4300
Writing: 21251 Ridgetop Circle, Suite #140, Sterling VA 20166
Inform the Medical Records Director of your complaint. Request a written summary of your conversation with the Medical Records Director as well as a written summary of his/her proposed solution to your complaint. If you feel that your complaints were not handled accordingly, you may contact the Virginia State Board of Medicine in Richmond at (800) 533-1560.

By signing below, I acknowledge that I have read, understand, and fully agree with all the information written in Loudoun Sports Therapy's HIPPA policy and am willing to abide by all said statements.

Patient Name (printed) Date

Patient Signature (parent/guardian if patient is under 18) Parent/ Guardian Name (printed) - (if patient under 18)