PATIENT REGISTRATION

3905 Dix Street NE
Washington, DC 20019
Admin@therapeutic-sessions.com
Office: 202-680-4864
Fax: 202-847-3769

First Name: _____ MI_____ Last Name_____
AS IT APPEARS ON INSURANCE CARD

DOB_____/_____/_____ Social Security # _____-____-_____ FOR INSURANCE PURPOSES ONLY

DO YOU HAVE A PREFERRED NICK NAME? ____ NO ____YES _____
OPTIONAL: PLEASE LIST NAME

HOME ADDRESS: _____
CITY_____STATE_____ ZIP CODE_____
HOME # (_____)_____**EMAIL:** _____
CELL # (_____)_____ **HOW WOULD YOU LIKE TO RECEIVE APPOINTMENT NOTIFICATIONS/REMINDERS?**
TEXT _____ EMAIL _____ HOME _____ WORK_____

PATIENTS EMPLOYER _____ OCCUPATION_____
CITY_____STATE_____ ZIP CODE_____ **WORK #** (_____)_____
REQUIRED FOR ALL WORKERS COMPENSATION CLAIM

EMERGENCY CONTACT: _____ RELATIONSHIP_____
CONTACT # (_____)_____ OR (_____)_____
DOES THIS PERSON LIVE WITH YOU _____ YES _____ NO

HOW DID YOU HEAR ABOUT US? _____
HAVE YOU HAD ANY FORM OF THERAPY (PT/OT/SP) THIS YEAR? _____ YES _____ NO
IF YES, WHEN? _____/_____/_____WHERE? _____

REFERRING PHYSICIAN _____ Phone # (_____)_____
PRIMARY PHYSICIAN _____ Phone # (_____)_____
TYPE OF INJURY _____ **DATE OF INJURY** _____/_____/_____
*****REQUIRED FOR WORKERS COMPENSATION /MOTOR VEHICLE ACCIDENT CLAIMS OR PERSONAL INJURY CLAIMS*

WAS THIS THE RESULT OF A **MOTOR VEHICLE ACCIDENT** _____ YES _____ NO
WORKERS COMPENSATION _____ YES _____ NO
DO YOU HAVE AN OPEN CLAIM _____ YES _____ NO

WHAT STATE DID THE INJURY OCCUR? _____
MVA OR WORKERS COMPENSATION CARRIER: _____
ADDRESS: _____
CITY_____ST_____ ZIP CODE_____

NOTE: THIS INFORMATION IS IMPORTANT FOR THE APPOINTMENT. WE MUST HAVE AUTHORIZATION PRIOR TO YOUR APPOINTMENT.

PLEASE COMPLETE ALL FIELDS AND SIGN ALL PAGES WHICH REQUIRE SIGNATURE

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WORKERS COMPENSATION/MVA/PERSON INJURY CLAIM/ATTORNEY INFORMATION:

CLAIM NUMBER: _____ **DATE OF INJURY**: ____/____/_____
CLAIMS ADJ NAME: _____ PHONE # (_____)_____
RN CASE MGR NAME: _____ PHONE # (_____)_____
ATTORNEY NAME: _____ PHONE # (_____)_____
DO YOU HAVE AN SIGNED AUTHORIZATION ON FILE WITH YOUR ATTORNEY? YES_____ NO _____ PENDING _____

IF YOUR VIST WAS NOT THE RESULT OF WORKERS COMPENSATION, MVA OR PERSONAL INJURY PLEASE COMPLETE THE INFORMATION BELOW.

PRIMARY HEALTH INSURANCE:	**SECONDARY HEALTH INSURANCE:**
_____	_____
MEMBER ID: _____	MEMBER ID: _____
GROUP #: _____	GROUP #: _____
MAILING ADDRESS: _____	MAILING ADDRESS: _____
CITY: _____ STATE:_____	CITY: _____ STATE:_____
ZIP:_____ PHONE: (_____)_____	ZIP:_____ PHONE: (_____)_____
ARE YOU THE POLICY HOLDER? _____YES _____ NO	ARE YOU THE POLICY HOLDER? _____YES _____ NO
IF NO, WHO IS THE POLICY HOLDER?	**IF NO**, WHO IS THE POLICY HOLDER?
NAME: _____	NAME: _____
WHAT IS YOUR RELATION TO THE INSURED? _____	WHAT IS YOUR RELATION TO THE INSURED? _____
POLICY HOLDERS DATE OF BIRTH: _____/_____/_____	POLICY HOLDERS DATE OF BIRTH: _____/_____/_____

FOR MEDICARE PATIENTS ONLY: HAVE YOU HAD ANY OCCUPATIONAL OR **PHYSICAL THERAPY/OCCUPATIONAL AND/OR SPEECH THERAPY** FOR ANY REASON SINCE **JANUARY 1ST? _____ YES ____ NO**
IF YES, DESCRIBE: _____

CONSENT FOR TREATMENT: I HEREBY AUTHORIZE THE PROFESSIONAL STAFF OF THERAPEUTIC SESSIONS, HEREAFTER REFERRED TO AS "TS" TO EXAMINE AND TREAT ME WITH THERAPY SERVICES FOR THE INJURY I HAVE BEEN REFERRED FOR.

ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO HEALTH PROVIDER: I HEREBY INSTRUCT THE AFOREMENTIONED INSURANCE COMPANY AND/OR ATTORNEY, MVA (PIP COVERAGE); WORKERS COMPENSATION CARRIER AND ANY OTHER INSURANCE THAT MAY BE INVOLVED REGARDING THI MATTER TO PAY BY CHECK (PAPER OR ELECTRONIC) MADE OUT TO AND MAILED DIRECTLY TO: **THERAPEUTIC SESSIONS** FOR PROFESSIONAL/MEDICAL EXPENSES ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER THE CURRENT INSURANCE POLICY AS PAYMENT TOWARDS THE TOTAL CHARGES FOR SERVICES RENDERED. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY**. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO THE ABOVE-MENTIONED ASSIGNEE AND I AGREE TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL FEES FOR NON-COVERED SERVICES AND/OR FEES, OVER AND ABOVE THE INSURANCE PAYMENT AS REQUIRED BY THE INSURANCE POLICY.

NOTICE OF PRIVACY PRACTICES: I HEREBY AUTHORIZE THAT I AM AWARE OF MY RIGHTS S IT PERTAINS TO HIPAA AND MY PROTECTED HEALTH INFORMATION (PHI). TS HAS OFFERED ME A COPY OF THE HIPAA POLICY AND NOTICE OF THEIR PRIVACY PRACTICES FOR MY OWN RECORDS.

THE FOLLOWING PERSON(S) LISTED BELOW HAVE BEEN AUTHORIZED FOR DISCLOSURE OF MY PHI, THIS WILL INCLUDE MEDICAL OR BILLING:

1. _____ ENTIRE MEDICAL RECORD ____ DIAGNOSIS & TREATMENT _____ BILLING ONLY_____
2. _____ ENTIRE MEDICAL RECORD ____ DIAGNOSIS & TREATMENT _____ BILLING ONLY_____

PATIENT SIGNATURE: _____ **PRINT** _____
DATE: _____/_____/_____ IF CHILD: PARENT/GUARDIANS SIGNATURE_____

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Hours of Operation for Patient Care:
Monday – Thursday 8:30am – 6:00pm
Friday - 8:30 am – 3:00 pm
Lunch - 1:00 pm – 2:00pm

CANCELLATION / NO-SHOW POLICY

We strive to provide our patients with excellent service and quality of care. Our commitment to your well-being and health care is something that we at *Therapeutic Sessions* take very serious.

Commitment to this program is critical for your success, this would include adherence to your treatment and set goals. **In order to obtain these goals it is imperative that you attend each appointment**.

We commit to providing reminders about all appointments. If for any reason you forget your appointment please call us so we can review your scheduled dates. We expect that you keep all appointments; however should you need to cancel or reschedule please note that we **REQUIRE a 24-Hour notice.**

****ALL LATE CANCELATION & NO SHOW APPOINTMENTS** will be charged **$25** for the missed appointment. The missed appointment will not be billed to health insurance or compensation carrier, this is considered patient responsibility.

ALL FEES associated with NO-SHOW appointments will be collected at check in for your next therapy session.

If you miss **three (3) appointments** within your series of appointments we will notify your Physician and or Claims Adjuster and may require a new referral/order to continue treatment.

Late arrival policy:

Patients arriving more than **15 minutes** late for a scheduled appointment without prior notification will be rescheduled for another day.

We thank you for choosing *Therapeutic Sessions* and look forward to working with you reach your goals.

The Staff of *Therapeutic Sessions!*

I HAVE READ AND UNDERSTAND THIS POLICY:

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

IF CHILD: PARENT/GUARDIANS SIGNATURE_____

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Therapeutic Sessions (TheraSessions) will use/disclose patient PHI by way of verbal/fax/mail and electronic transmission. A PHI Record Trail form will be used to keep record of all patient disclosures.

Patients have rights to:

- Receive written notice of agency privacy practices related to PHI use/disclosure
- Restrict use and disclosure, although TheraSessions is not required to agree.
- Have PHI communication to them by alternate means and at alternate locations to protect confidentiality.
- Request inspection and amendment of PHI and obtain copies of PHI, with some exceptions
- Request a history of disclosure for six years prior to request, except for disclosure made for treatment, payment or healthcare operations, or for authorized disclosures.
- Contact designated persons regarding any privacy concern or breach of privacy within **TheraSessions or at Health and Human Services (HHS).**

TheraSessions is legally responsible to:

- Document patients' receipt of the Notice of Privacy Practices and patients' request for copies of their medical records, or reports of non-routine disclosure of PHI
- Document any complaints of breaches as well as the resolution.
- Secure patient data while traveling to and from a patient's home and do not discuss intimate information about the patient and family with others.
- Protect computer data by controlling access with password protection and automatic log-off features, and by using special screens to prevent anyone from reading information unless he or she is directly in front of it.
- Taking reasonable safeguards to avoid being overheard when discussing a patient's treatment with others healthcare providers.

Should any patient wish to lodge a complaint regarding **TheraSessions Privacy Practices**, please contact **Necothia Bowens, Office Manager (TheraSessions) at 202-680-4864** or file in writing, either on paper or electronically.

Anyone can file written complaints with Office of Civil Rights by mail, fax or email. If you need help call toll free 1-800-368-1019

Region III – DE, DC, MD, PA, VA WV
Office of Civil Rights
US Department of Health & Human
Services 150 S Independence mall
West –Suite 372 Philadelphia, PA
19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

I acknowledge I have received a copy of **TheraSessions Notice of Privacy Practices**.

PATIENT SIGNATURE: _____ **PRINT** _____

DATE: _____/_____/_____ IF CHILD: PARENT/GUARDIANS SIGNATURE_____

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This form must be completed before the evaluation.

VERY IMPORTANT FOR EVAL / RE-EVAL: PLEASE COMPLETE ALL FIELDS AND ANSWER EACH QUESTION

Patient Name: _____ **Date**: ____/_____/_____

Describe the problem that brings you to therapy:

_____
_____
_____

What activity/task would you like to be able to return to after Physical Therapy? (GOALS):

(EX: Roller Skating, Dancing, Walking in community, lifting Child/Grand Children, weights, etc.)_____

_____
_____
_____

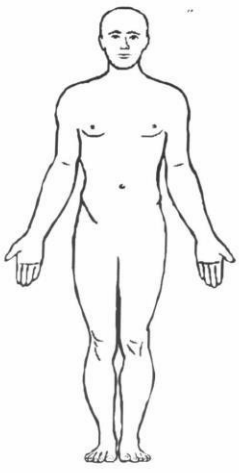
Date of Injury: ____/_____/_____ **Date of 1st Symptom**: ____/_____/_____**Height** _____**Weight** _____

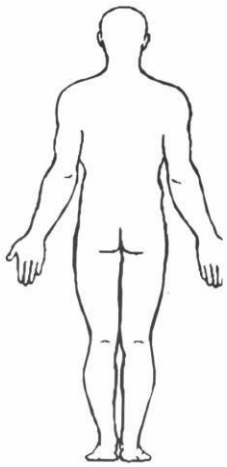
(**REQUIRED FOR ALL CAREFIRST BCBS**) (**When did you notice the pain?**)

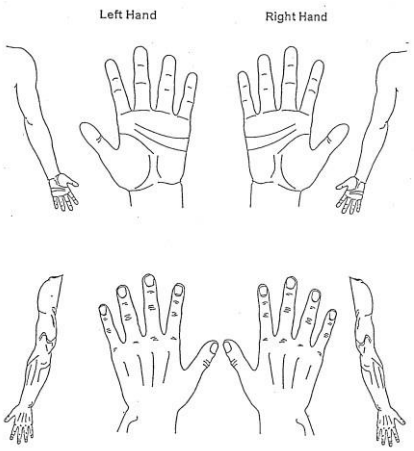
Do you have pain? _____NO _____YES: **If yes**, please rate your pain on the following pain scale:

0 1 2 3 4 5 6 7 8 9 10
(none) (severe)

If yes, please indicate on the drawings below where your pain is:







List any test within the past six (6) months: X-Ray _____CT Scan_____ MRI_____ EMG_____
ECG _____ Other:

Please list date(s) _____ , _____ , _____ , _____, _____

HAVE YOU HAD SURGERY PERTAINING TO THIS? _____ NO ____ YES: IF YES, WHEN _____/_____/_____

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Medical History

Allergies	O YES O NO	Dizzy Spells	O YES O NO	MRSA	O YES O NO
Anemia	O YES O NO	Emphysema/Bronchitis	O YES O NO	Multiple Sclerosis	O YES O NO
Anxiety	O YES O NO	Fibromyalgia	O YES O NO	Muscular Disease	O YES O NO
Arthritis	O YES O NO	Fractures	O YES O NO	Osteoporosis	O YES O NO
Asthma	O YES O NO	Gallbladder Problems	O YES O NO	Parkinson's	O YES O NO
Autoimmune	O YES O NO	Headaches	O YES O NO	Rheumatoid	O YES O NO
Cancer	O YES O NO	Hearing Impairment	O YES O NO	Seizures	O YES O NO
Cardiac Conditions	O YES O NO	Hepatitis	O YES O NO	Smoking	O YES O NO
Cardiac Pacemaker	O YES O NO	High Cholesterol	O YES O NO	Speech Problem s	O YES O NO
Chemical	O YES O NO	High/Low Blood Pressure	O YES O NO	Strokes	O YES O NO
Circulation Problems	O YES O NO	HIV/AIDS	O YES O NO	Thyroid Disease	O YES O NO
Currently Pregnant	O YES O NO	Incontinence	O YES O NO	Tuberculosis	O YES O NO
Depression	O YES O NO	Kidney Problems	O YES O NO	Vision Problems	O YES O NO
Diabetes	O YES O NO	Metal Implants	O YES O NO		

Existing or Relevant Previous Conditions

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? O Yes O No
Two or more falls in the last year? O Yes O No
Patient is at risk for falls? O Yes O No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____
Body Region: _____ Surgery Type: _____ Date: _____/_____/_____
Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Current Medications ☐ **LIST SCANNED TO EMR** ☐ **Currently not taking any medications**

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

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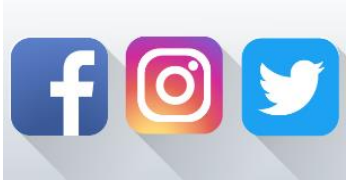
Therapeutic Sessions Appt Reminders:

Front Desk Staff: **Necothia Bowens – Office Manager** **Kimberly Trejo - Admin Asst / PT Aide**	***Contact Phones: 202-680-4864*** ***Emails: Admin@therapeutic-sessions.com***	
Arrival Time	***5 mins prior to appt*** **Sign in and Date sign in sheet**	The lockers are behind the reception desk near the back exam room. We ask after you have secured your personal belongs please return to waiting area. ***The PT or PT Aide will come to get you.***
What to wear?	Wear comfortable clothing and patients with knee injuries should bring a pair of shorts. Shoes with rubber soles are preferred. 	
Waiting Area	Near front entrance	**There is limited space so we ask that family members wait in the waiting area**
NEED TRANSPORTATION: Most insurance companies offer transportation, please check with your health insurance by **calling the customer service number on the back of your insurance card.**	**Cancellation / No Show** **Call 24 hours prior** **No Show - $25 Fee** **Three consecutive** cancelled appts or No Show appointments, you will need to report to your MD to continue Therapy	
Inclement Weather/Office Closures	Notification of Office closure/delays will be sent by one of the following: **Voice Alert** – You will receive a voice mail call from TS Staff **Text Message** – You will receive a text message **Email** – You will receive an email message from ***OptimisPt*** Patient Portal Recorded Message on Therapeutic Sessions Telephone System	
Therapeutic Sessions observes the following Holidays (Office Closed)	New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day following Thanksgiving and Christmas Day	
Social Media Check in & Follow us  	If you **follow us on Social Media**, Check in: **@TheraSessions** We only ask that you NOT take pictures of others in the Clinic, we don't wish to violate anyone's privacy. We welcome your feedback: **write us a review on Yelp or Google (Therapeutic Sessions)**	

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