

DATE OF EVAL: \_\_\_\_\_ PT: \_\_\_\_\_ TO#: \_\_\_\_\_

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 INFORMATION- PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING**

PRIMARY INSURANCE \_\_\_\_\_ ID \_\_\_\_\_ GROUP # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Do you have a secondary insurance?  Yes  No (if yes, please make sure that information is listed below)

**SECONDARY INSURANCE INFORMATION- PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING**

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 \_\_\_\_\_

**By signing below, I acknowledge that all of the above information is accurate. I have supplied copies of all of my health insurance cards to the front desk upon registration. I understand that if my health insurance is not on file or I fail to supply the correct insurance information, I may be responsible for all balances. 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: \_\_\_\_\_

# Medical History Questionnaire

DbA Elite Sports Medicine and Physical Therapy, LLC/Progress Rehabilitation Network, LLC

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

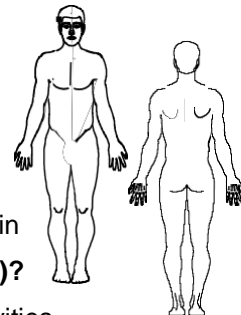
Check all that apply  Pain unrelieved by rest  Pain at night  Dizziness/Fainting  Recent Infection/Fever

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 (office visits, telehealth, e-visits, and screenings) 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

Dba Elite Sports Medicine and Physical Therapy, LLC/Progress Rehabilitation Network, LLC

## 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 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 a Elite Sports Medicine and 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 \_\_\_\_\_

# COVID-19 Questionnaire

**If you answer YES to Question #1, you may skip Questions #4 and #5, and sign and date at the bottom of this form.**

**If you answer YES to Questions #2 and/or # 3, PLEASE LET US KNOW IMMEDIATELY!**

1) Are you 14 days or more past receiving the final dose of the COVID 19 Vaccine? YES NO

If YES, please provide date of final dose \_\_\_\_\_ and the type (circle) Pfizer Moderna J&J

Please bring a copy of your vaccine card to your first appointment for us to scan into your chart.

2) Have *you, a family member or other close contact experienced* any of the following symptoms or *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.** \*YES NO

3) Are you currently taking any medications to suppress a fever? \*YES NO

4) Have *you or any close contacts* had any known exposure to the Corona Virus in the past 14 days?

\*YES NO

5) Are you wearing a mask when in public places and when socializing indoors, and practicing social distancing?

YES \*NO

I understand that it is my responsibility to immediately inform dba Elite Sports Medicine and Physical Therapy,, LLC if I develop any of symptoms noted in #2 above\*\*; if I have had close contact with anyone else with these symptoms or that has been 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 need to be made for my care (e.g. my appointment *may* need to be re-scheduled or virtual visits will be offered) in order to maintain the lowest possible risk of the spread of COVID-19 at our office. I understand that dba Elite Sports Medicine and 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 socially distanced from others.

Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



Db a Elite Sports Medicine and 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 571-261-9900 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