Optimum Physical Therapy & Sports Medicine

PATIENT INFORMATION

Personal Information*

Prefix: Mr./Mrs./Other:_____ Patient*:_____ Suffix: Jr./Sr./Other: _____
(Last, First, Middle Initial)

Previous Name:_____ Preferred Name: _____

Mailing Address*: _____
(Street Address, City, State, Zip)

Home #:_____ Cell #:_____ Work #:_____ Ext: _____

Method of Contact for Appointment Reminders: ☐ Text Message ☐ Home Phone ☐ Cell Phone

Primary Care Provider (PCP):_____ Address:_____ Phone #: _____
(First, Last)

Referring Provider:_____ Address:_____ Phone #: _____
(First, Last)

Date of Birth*:_____ Sex*:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
(mm/dd/yyyy)

Social Security #:_____-_____-_____ Employer Name:_____ Occupation:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Email: _____

Race*: ☐ Caucasian/White ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other:_____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: _____

Language*: ☐ English ☐ Spanish ☐ Other: _____

Pharmacy Name*:_____ Address:_____ Phone #: _____
(Street Address, City, State, Zip)

Emergency Contact*

Name:_____ Relationship: _____
(Last, First)

Address: _____
(Street Address, City, State, Zip)

Home #:_____ Work #:_____ Cell #: _____

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name:_____ Date of Birth:_____ Sex:_____ Social Security #:_____-_____- _____
(Last, First, mm/dd/yyyy)

Address: _____
(Street Address, City, State, Zip)

Home #:_____ Cell #:_____ Work #:_____ Ext: _____

Primary Insurance Information*

Insurance Name:_____ Member ID #:_____ Relationship to Insured:_____

Employer:_____ Group #:_____ Effective Date: _____
(mm/dd/yyyy)

Insured's Information* - (if not self)

Name:_____ Date of Birth:_____ Sex:_____ Social Security #:_____-_____- _____
(Last, First, mm/dd/yyyy)

Relationship to Insured:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____
(Street Address, City, State, Zip)

Home #:_____ Work #:_____ Cell #: _____

Secondary Insurance Information

Insurance Name:_____ Member ID #:_____ Relationship to Insured:_____

Group #:_____ Effective Date: _____

Secondary Insured's Information - (if not self)

Name:_____ Date of Birth:_____ Sex:_____ Social Security #:_____-_____- _____
(Last, First, mm/dd/yyyy)

Relationship to Insured:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____
(Street Address, City, State, Zip)

Home #:_____ Work #:_____ Cell #: _____

CONSENT INFORMATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration**. X_____(Please initial)**

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X_____(Please initial)**

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. **X_____(Please initial)**

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X_____(Please initial)**

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis **Date**

_____

Relationship (if any)

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

_____
Patient's Name

I have a received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

_____
Signature

Date:_____

_____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**

LOUDOUN MEDICAL GROUP PC
NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. N.W., Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

Who Does this Notice Apply to?

Loudoun Medical Group, PC ("LMG"), has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

LMG understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from _____ until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- *Treatment*. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.
  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- *Payment*. We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in

connection with payment for your care.

- *Health care operations*. We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.

- In case of suspected child abuse, to the appropriate governmental authority.

- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.

- Unless you object, to friends or family members who are involved in your medical care.

- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.

- To health oversight authorities, for regulatory, licensing and other legal purposes.

- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.

- To law enforcement agencies, subject to applicable legal requirements and limitations.

- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

- To Funeral Directors/Medical Examiners/Coroners in the event of your death.

- When required by Federal, State or Local law.

- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.

- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appoint-ments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, LMG would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

- Right to Inspect and Copy. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge based on our costs.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support

the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for LMG;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

  To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with LMG, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.

Optimum Physical Therapy & Sports Medicine

Cancellation and No-Show Policy

Due to the high demand and the general nature of Physical Therapy, it is important to keep your scheduled appointments or provide sufficient notice of cancellations. Optimum Physical Therapy's Cancellation and No-Show Policy is listed below.

After the first offense, a fee of $50.00 will be charged for all missed appointments or appointments canceled without 24-hours' notice.

By signing this form, I acknowledge the above stated policy and assume responsibility for my missed appointment(s) cancelled without 24-hours' notice.

_____ _____

Patient/Guardian Signature Date

Optimum Physical Therapy & Sports Medicine

PHYSICAL THERAPY MEDICAL SCREENING QUESTIONAIRE

Name:_____Date of Birth:_____ Age: _____

Are you latex sensitive? ☐ YES ☐ NO Do you smoke? ☐ YES ☐ NO

Do you have a pacemaker? ☐ YES ☐ NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ YES ☐ NO

List any **drug allergies or contrast/dye allergies:** _____

Have you RECENTLY noted any of the following? (Check all that apply.)

- ☐ fatigue
- ☐ numbness/tingling
- ☐ constipation
- ☐ fever/chills/sweats
- ☐ muscle weakness
- ☐ diarrhea
- ☐ nausea/vomiting
- ☐ dizziness/lightheadedness
- ☐ shortness of breath
- ☐ weight loss/gain
- ☐ heartburn/indigestion
- ☐ fainting
- ☐ difficulty maintaining balance while walking
- ☐ difficulty swallowing
- ☐ cough
- ☐ falls
- ☐ changes in bowel/bladder function
- ☐ headaches

Have you EVER been diagnosed with any of the following conditions? (Check all that apply.)

- ☐ cancer
- ☐ depression
- ☐ thyroid problems
- ☐ heart problems
- ☐ lung problems
- ☐ diabetes
- ☐ chest pain/angina
- ☐ tuberculosis
- ☐ osteoporosis
- ☐ high blood pressure
- ☐ asthma
- ☐ pneumonia
- ☐ multiple sclerosis
- ☐ circulation problems
- ☐ rheumatoid arthritis
- ☐ epilepsy
- ☐ blood clots
- ☐ other arthritic condition
- ☐ eye problem/infection
- ☐ stroke
- ☐ bladder/urinary tract infection
- ☐ ulcers
- ☐ anemia
- ☐ kidney problem/infection
- ☐ liver problems
- ☐ bone or joint infection
- ☐ hepatitis
- ☐ sexually transmitted disease/HIV
- ☐ chemical dependency (i.e. alcoholism)
- ☐ pelvic inflammatory disease

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of following conditions? (Check all that apply.)

- ☐ cancer
- ☐ diabetes
- ☐ tuberculosis
- ☐ heart problems
- ☐ stroke
- ☐ thyroid problems
- ☐ depression
- ☐ high blood pressure

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

If yes to either, is this something with which you would like help? ☐ YES ☐ YES, but NOT today ☐ NO

Please list any medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____

_____

Have you ever taken steroid medications for any medical conditions? ☐ YES ☐ NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ YES ☐ NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

_____

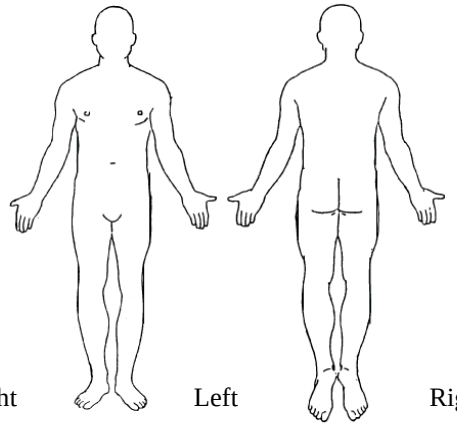
What date (roughly) did your present problem start? _____

My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

Treatment received so far for this problem (i.e. chiropractic, injections, surgery): _____

Please list special tests performed for this problem (i.e. x-ray, MRI, labs): _____

Body Chart: Please mark the areas where you feel symptoms on the chart with the following symbols to describe your symptoms: ↓ Shooting/sharp pain ○ Dull/aching pain ||| Numbness = Tingling



Right Left Right

My symptoms currently:

☐ Come and go

☐ Are constant

☐ Are constant, but change with activity

Using the 0 to 10 scale, with 0 being *"no pain"* and 10 being the *"worst paint imaginable"*, please describe:

Check mark your current level of pain while completing this survey: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Check mark the best your pain has been during the past 24 hours: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Check mark the worst your pain has been during the past 24 hours: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Easing Factors: Identify up to 3 important positions or activities that make your symptoms *better*:

1. _____
2. _____
3. _____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a results of your problem.

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After activity

When are your symptoms the best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After activity

Patient Name: _____Patient Signature: _____