MOUNT VERNON REHABILITATION MEDICINE ASSOCIATES

2501 Parkers Lane, Alexandria, VA 22306 (703) 664-7285 Fax (703) 664-7568
3700 Joseph Siewick Dr, Ste 408, Fairfax, VA 22033 (703) 391-4212 Fax (703) 391-4219
3300 Gallows Rd, Falls Church, VA 22042 (703) 776-6090 Fax (703) 776-6085
19440 Golf Vista Plaza, Ste 210, Leesburg, VA 20176 (703) 729-0141 Fax (703) 729-0143

We are Physiatrists!

Physiatrists, or rehabilitation physicians, are nerve, and bone experts who treat injuries or illnesses that affect how you move.

Rehabilitation physicians are medical doctors who have completed training in the medical specialty of physical medicine and rehabilitation (PM&R). Specifically, rehabilitation physicians.

- Diagnose and treat pain
- Restore maximum function lost through injury, illness or disabling conditions
- Treat the whole person, not just the problem area
- Lead a team of medical professionals
- Provide non-surgical treatments
- Explain your medical problems and treatment/prevention plan

The job of a rehabilitation physician is to treat any disability resulting from disease or injury, from sore shoulders to spinal cord injuries. The focus is on the development of a comprehensive program for putting the pieces of a person's life back together after injury or disease-without surgery.

Rehabilitation physicians take the time needed to accurately pinpoint the source of an ailment. They then design a treatment plan that can be carried out by the patients themselves or with the help of the rehabilitation physician's medical team. This medial team might include other physicians and health professionals, such as neurologist, orthopedic surgeons, and physical therapists. By providing an appropriate treatment plan, rehabilitation physicians help patients stay as active as possible at any age. Their broad medical expertise allows them to treat disabling conditions throughout a person's lifetime.

We provide services for patients with:

- Musculoskeletal/Spine problems.
- Brain Injury Trauma
- Spinal Cord Injury
- Neurological Disorders
- Amputation Rehabilitation
- Stroke Rehabilitation/Inpatient Rehab
- Orthopedic Trauma
- Work Related and Sports Injuries (Concussions)
- General Medical Rehabilitation
- EMG & Nerve Conduction Studies
- Injectable Medicine for Spasticity (Botox or Xeomin)

Mount Vernon Rehabilitation Medicine Associates

New Patient Registration Form

Patient Last name: _____ **First name:** _____ **MI:** ____

Date of Birth: _____ **Age:** _____ **SS#:** _____ **Sex:** □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered □ Separated

Home address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home phone: _____ **Work phone:** _____ **Mobile phone:** _____

Email address: _____ **Preferred Language:** □ English □ _____

Race: _____ **Ethnic Background:** _____ **Place of Birth:** _____

Emergency contact person: _____ **Contact phone #:** _____

Who referred you to our office? _____

Who is your primary care provider? _____

Preferred Pharmacy: _____

Location: _____

Phone # (if known): _____

Insurance Information:

	Primary Insurance	Secondary Insurance (if applicable)
Carrier		
Name of policy holder (if different)		
Policy Number		
Group Number		
Address		

Worker's Compensation Information (if applicable):

Date of injury:	**Case Manager Name:**
Claim Number:	**Case Manager Phone:**
Insurance Company:	**Case Manager Fax:**

Consent regarding payment/insurance:

I hereby authorize Mount Vernon Rehabilitation Medicine Associates to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of all information necessary to secure payment of benefits to my insurance company or health care program.

I understand that I am financially responsible for any and all charges on my account whether or not paid by my insurance plan.

Patient signature: _____ **Date:** _____

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Reason for Visit

Please describe the symptoms that have brought you to our office:

_____

_____

_____

When did this problem begin: _____

Did your problem begin after an injury? □ Yes □ No

If yes, is this injury related to: □ Work □ School □ Motor vehicle crash □ Sport

Please describe how the injury occurred in detail: _____

_____

_____

Have you had any prior evaluation of this problem? □ Yes □ No

If yes: □ Physical examination □ X-ray □ CT scan □ MRI □EMG

□ Other _____

When was this completed? _____ Where? _____

Have you had any of the following treatments for your current problem?

□ Physical therapy □ Chiropractor □ Injections □ Surgery

□ Medications (please list) :

_____ □ Helped □ Didn't help □ Had adverse effect

_____ □ Helped □ Didn't help □ Had adverse effect

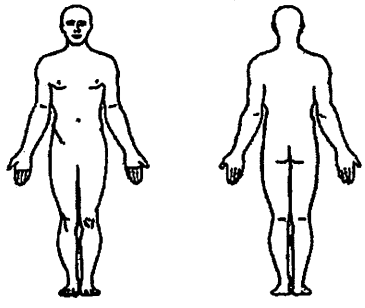
_____ □ Helped □ Didn't help □ Had adverse effect

What makes your current problem better? _____ **Worse?** _____

Do you have any pain today? □ Yes □ No

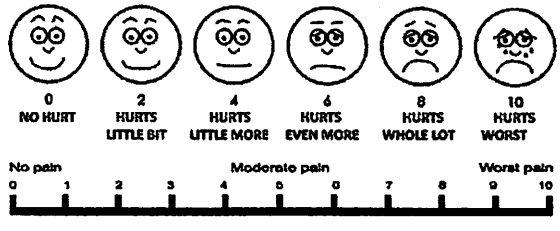
If yes:

Please indicate where you have pain



_____

Please rate your pain on a scale of 0 to 10



_____

What is your current Height and Weight: _____Feet_____Inches _____Pounds

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Medical History

Past Medical History: Have you ever had any of the following conditions? (Check all that apply)

□ Anemia	□ Brain injury	□ Heart disease	□ Polio
□ Anxiety	□ Cancer	□ Hypertension	□ Rheumatoid arthritis
□ Arthritis	□ COPD	□ Insomnia	□ Seizures
□ Asthma	□ Depression	□ Kidney disease	□ Stroke
□ Blood clot	□ Diabetes mellitus	□ Liver disease	□ Thyroid disease
□ Broken bones	□ Glaucoma	□ Osteoporosis	□ Ulcers

Other Medical Problems: Please list

_____
_____
_____

Prior surgeries/procedures: Please list

_____
_____
_____

Current Medications: Please list

_____
_____
_____
_____
_____

Current Nutritional Supplements: Please list

_____
_____
_____
_____
_____

Allergies: _____

Family History:

Do/did you have any close family members with one of the following conditions? If yes, who?

Back or neck problems? _____
Cancer? _____
Heart disease? _____
Multiple sclerosis? _____
Rheumatoid arthritis? _____
Stroke? _____

Are there any diseases that seem to run in your family? _____

Social History:

Tobacco Use: □ Never □ Former Smoker □ Current Smoker □ Trying to quit □ Current chewer

Alcohol Use: □ Never □ Rare □ Weekly □ Daily □ Heavy use

Have you ever had problematic use of alcohol or prescription or recreational drugs? □ Yes □ No

Work status: □ Employed □ Student □ Retired □ Homemaker □ Unemployed □ Disabled
Occupation: _____

Exercise regimen: _____

Do you have children? □ Yes □ No

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Review of systems

Please check any/all symptoms you have experienced in the past week

General: ◻ Fever ◻ Sweats ◻ Low energy ◻ Poor appetite ◻ Trouble sleeping ◻ Weight change

Eyes: ◻ Blurry vision ◻ Double vision ◻ Irritation

ENT: ◻ Poor hearing ◻ Ringing in the ears ◻ Sinus problems ◻ Difficulty swallowing

Cardiovascular: ◻ Chest pain ◻ Dizziness ◻ Palpitations ◻ Poor circulation

Pulmonary: ◻ Shortness of breath ◻ Wheezing ◻ Cough

Gastrointestinal: ◻ Abdominal pain ◻ Nausea ◻ Vomiting ◻ Diarrhea ◻ Constipation

Genitourinary: ◻ Frequent urination ◻ Burning with urination ◻ Urinary retention ◻ Incontinence

Hematologic: ◻ Easy bleeding ◻ Easy bruising ◻ Paler than usual skin

Musculoskeletal: ◻ Joint pain ◻ Muscle pain ◻ Joint swelling ◻ Stiffness ◻ Difficulty walking

Neurologic: ◻ Weakness ◻ Numbness ◻ Tingling ◻ Slurred speech ◻ Poor balance ◻ Tremor

Mood: ◻ Anxiety ◻ Depression

Is there anything you would like us to know?

_____

_____

_____

_____

_____

Do you have a specific goal for this visit?

_____

_____

_____

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Patient:_____

Check One: Ethnicity

Hispanic or Latino ___
Not Hispanic or Latino____
Declined to specify___

Check One: Race

American Indian or Alaska Native ____
Asian ____
Black or African American ___
Native Hawaiian or Other Pacific Islander ____
White ____
Decline to Specify

Check One: Preferred Language

English __
Spanish ___
Other ____ Please specify _____

Check One: Smoking Status:

Never smoked ___
Former smoker ____
Current everyday smoker ___
Heavy tobacco smoker ____
Unknown if ever smoked___
Smoker, current status unknown
Current some day smoker
Light tobacco smoker

Current Height_____
Current Weight _____

Email Address Required:

_____**(This will be used to communicate upcoming appointments reminders and/or account balances only)**

MOUNT VERNON REHABILITATION MEDICINE ASSOCIATES

Receipt of Notice of Privacy Practices and HIPAA
Written Acknowledgement Form

I, _____have received a copy of Mount Vernon Rehabilitation Medicine Associate notice of privacy practices and HIPAA.

_____ _____

Signature of Patient/Representative Date

NOTICE OF PRIVACY PRACTICES AND HIPAA

MOUNT VERNON REHABILITATION MEDICINE ASSOCIATES

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

The Health Insurance Portability & Accountability Act of 1966 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used an disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. We are committed to the privacy of your personal identifiable health information (PHI) and will use strict privacy standards to protect it from unauthorized use or disclosure.

Understanding Your Health Record: Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made,. Typically, this record contains your symptoms, examination and test results, diagnosis and treatment plan. This information is referred to as a health or medical record. Understanding what is in your record and how your health information is used helps you to ensure its accuracy and make more informed decisions when authorizing disclosure to others.

Uses and Disclosures That are permitted without your consent or authorization: We may share your PHI, as allowed by federal law, for health oversight activities. When consistent with Virginia Law, if we believe in good faith that the use of the PHI is necessary, we will release your PHI to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

Your PHI can be shared for judicial or administrative proceedings, with public authorities for law enforcement reasons, for activities deemed necessary by appropriate military command authorities, and to coroners, funeral directors or medical examiners (about decedents). We can also release your PHI in compliance with worker's compensation or similar programs established by law.

We may release your PHI to secure payment for health care services provided by our practice such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Your PHI may also be used or disclosed for health care operations which include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. This information will then be used to continually improve the quality and effectiveness of the health care and services we provide.

We may use and disclose your PHI for treatment to provide, coordinate or manage your health care and related services with other health care providers.

We may use your PHI to contact you wit appointment reminders or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. (please inform us if you do not wish to be contacted for appointment reminders).

Required Uses and Disclosure: We are required to disclose your PHI, upon request, to the Secretary of the United States Department of Health and Human Services in connection with the investigation of our compliance with federal privacy regulations.

Right to Inspect and Copy Medical Information: Your health record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to inspect and copy your PHI subject to certain limitation. We may exclude information complied in anticipation of legal proceedings. Virginia law prohibits you from inspecting and obtaining copies of your medical records if your attending physician or clinical psychologist has filed a written statement that your review of these records would be injurious to your health. Our practice charges a fee to cover the cost of copying your PHI.

Right to Request Restrictions on Use and Disclosure: any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent of the actions we may already have taken relying on your authorization. You may request us to limit our communication with you to a certain way or location, for example, to call you only at work or by mail.

If you are present and give us verbal permission, we may share your PHI with a family member, friend or another person of your choosing. If you are not present or are incapacitated and it is an emergency, we may share your PHI with a family member or a friend if sharing your PHI is in your best interest.

Right to Amend PHI: You have the right to request us, in writing, to amend your PHI if you believe the information is inaccurate or incomplete, but you cannot have any information deleted from you PHI. We may deny your request for amendment if it is determined that the information at issue is accurate and complete or if it was not created by our practice.

Maintenance and Destruction of Records: We will maintain your records for a minimum of six(6) years following your last date of service. Records eligible for destruction will be disposed of in a manner that fully protects patient confidentiality. There will be no further notice given prior to the destruction of records.

Information Protection: We keep you oral, written and electronic PHI safe using physical, electronic and procedural means,. These safeguards follow federal and state laws. We require our employees to protect PHI through written policies and procedures. PHI is limited to only those employees who need the data to do their job.

We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We are required to follow the privacy notice that is currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions. Effective for all PHI that we maintain. We will post any revisions to our notice and you may request a copy of the revised Notice of Privacy Practices from this office.

If you feel your privacy protections have been violated, you have the right to file a written complaint with our office or with the Department of Health and Human Services. We will not penalize or discriminate against you in any manner if you choose to file a complaint.

For more information or to file a complaint, please contact:

Privacy Officer
2501 Parkers Lane
Alexandria, VA 22306

-or-

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave, SW
Washington, DC 20201