Allied Health Solutions, LLC

REGISTRATION FORM

(PLEASE PRINT)

PATIENT INFORMATION

Patient's last name: First: Middle:			Sex:	Marital status
Street Address		City:	State:	ZIP Code:
Home Phone:	Cell Phone	Work Phone	*I authorize* **AHS*** *to communicate my Health Information via below* EMAIL	
Patient Date of Birth	Patient Social Security #:	Emergency Contact Name & Tel #:		
Is this Accident Related? ❑ Yes ❑ No	Select ❑ Auto ❑ WC ❑ Other	Location of Injury/Accident ❑ VA❑ DC❑ MD ❑ Other _____(Specify)	Date of Injury / Accident:	
Referring Physician:		Tel#	Fax #	

Health Insurance

Subscriber 's Name &	Social Security #	Date of birth:	Subscriber's Tel #:	Relationship to Patient:
Primary Insurance:	Policy #:	Group:	Tel #	
Secondary Insurance:	Policy #:	Group:	Tel #	

Workman's Compensation

Employer Name & Address:		Employer Tel #	Employment Status:
Insurance Name & Address :			Tel #
Adjustor / Case Manager Name		Claim# :	Tel #
Was Injury Reported Supervisor: ❑ Yes ❑ No	Date Reported	Supervisor Name:	Tel #

Auto Accident

Auto Insurance / Lien Company Tel #	Claim #	Adjuster Name Tel #:
Attorney Name:	Phone #:	Fax#

Guarantor

Guarantor Name (Responsible Party):	DOB	Tel #:	Relation to Patient
Address:	Email:		

I authorize **AHS*** (Allied Health Solutions) to release my information as needed to obtain authorizations and secure payment for services.

PRINT NAME
Patient/Parent or Guardian

Signature
Patient/Parent or Guardian

Date

Allied Health Solutions, LLC

2841 Hartland Road, Suite 403
Falls Church, Virginia 22043
Phone (703) 646-2250 • Fax (703) 991-5649

MEDICAL HISTORY FORM

NAME _____ DATE _____

Are you presently working? ☐ Y ☐ N

Date of injury / onset _____

Have you experienced these symptoms before? ☐ Y ☐ N

Have you had a related surgery? ☐ Y ☐ N

If Yes, please give date _____

If female, are you pregnant? ☐ Y ☐ N

Do you have or have you had any of the following:

Diabetes	☐ Y ☐ N	Metal Implants/Pacemaker	☐ Y ☐ N
Chest Pain/Angina	☐ Y ☐ N	Fractures	☐ Y ☐ N
Osteoarthritis	☐ Y ☐ N	Dizziness/Fainting	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Cancer	☐ Y ☐ N
Heart Disease	☐ Y ☐ N	Stroke	☐ Y ☐ N
Seizures	☐ Y ☐ N	Asthma/Breathing Difficulty	☐ Y ☐ N

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

Do you have any allergies? ☐ Y ☐ N

If yes, please list _____

Are you presently taking any medication? ☐ Y ☐ N

If yes, please list what medication and for what condition

_____

_____

Do you participate in any sports, exercise program or activities on a regular basis? ☐ Y ☐ N

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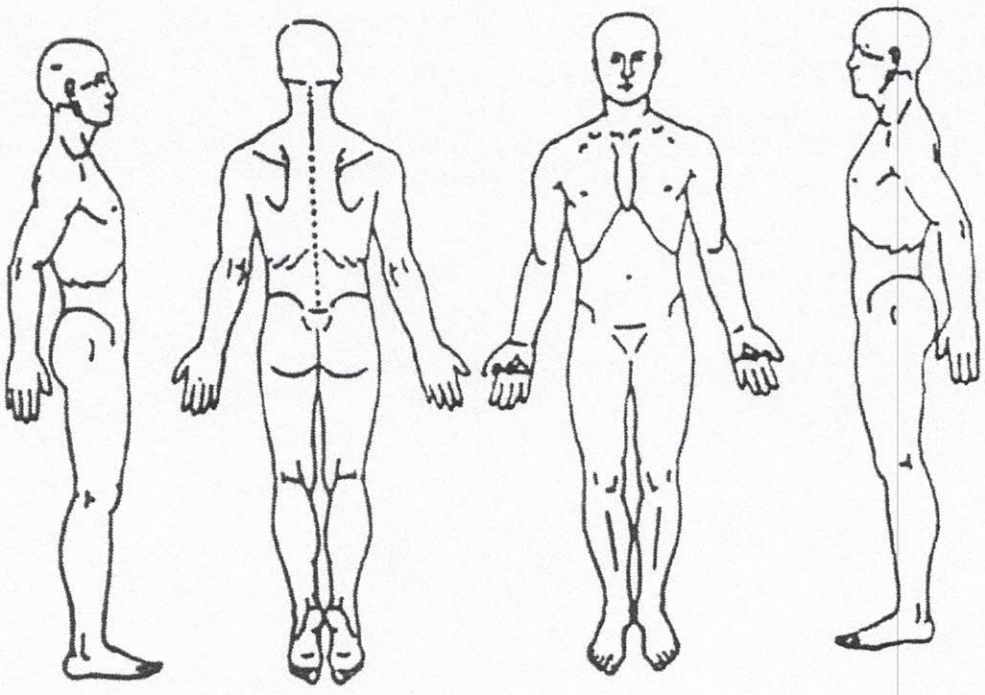
Please indicate below where your symptoms are located:



KEY

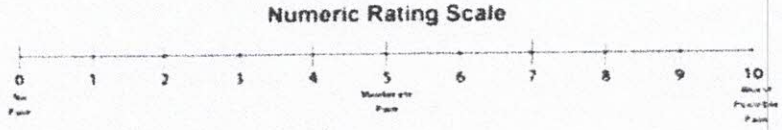
Numbness =======

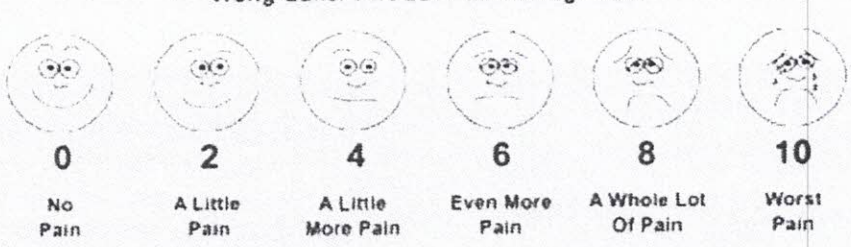
Pins and Needles 00000000

Burning Pain XXXXX

Stabbing Pain ////////////

If you are having pain, please rate the intensity of your pain on the scale below:





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CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to Allied Health Solutions, LLC. My treatment plan has been explained to me by the treating physical therapist. I understand that I have the right to ask and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have this facility provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature _____ Date _____

Signature of Parent / Guardian _____ Date _____

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RECORDS RELEASE FORM

Patient Name _____

RELEASE OF INFORMATION

I authorize Allied Health Solutions, LLC to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my (Doctor) _____, and (Insurance Company) _____ for communication and care coordination on my behalf. I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis.

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Witness Date

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HIPAA NOTICE OF 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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physical therapist's practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage our health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Allied Health Solutions, LLC.For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Other examples might include: employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision accreditation, certifications, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintain compliance programs, and business management and general administrative activities. We may call you in the waiting room by your name when we are ready to see you.

Law Enforcement: Your health information maybe disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states' public health department.

Other Permitted and Required Uses & Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the providers practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend and submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Allied Health Solutions, LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

I have read and understand all above authorizations and policies and I agree to them.

Patient/Legal Guardian Signature	Patient Name	Date	Witness

Allied Health Solutions, LLC

Appointment Cancellation/No Show/Late Policy

Our goal is to provide quality individualized care in a timely manner without compromising quality or our mission to provide excellent care. "No Shows" and late cancellation inconvenience those in need of treatment. In an effort to make your visit more comfortable we have implemented the following policies:

Cancellation of an Appointment

Please call/text our office promptly if you need to cancel or reschedule your appointment time. **We require that you call 24 hours in advance.**

As a courtesy, you will receive email and text message reminders at least 24 hours in advance. If you are not able to keep your appointment, we will be happy to reschedule it for you. Please do give us 24 hour advance notice to cancel or reschedule.

No Shows

A "No Show" is someone who is not present at the time of their scheduled appointment and has not provided adequate notice. We understand that emergencies do occur. **We require pre-payment of $25 after 1 "No Show" missed appointment.**

Late Arrivals

If a patient is 30 minutes late for an appointment, the appointment will need to be rescheduled. This is to ensure that the patients after you are seen on time. You may be given the option to wait for another appointment time on the same day if cancellations occur and one is available.

We are careful as to not overbook our schedule to ensure quality appointment for each patient. We highly recommend that patients be early for their appointment. We book our day to ensure that nobody's appointment is rushed or shortened, and our therapists have the time they need to take proper care of each patient. We appreciate your compliance and understanding.

_____ _____

Patient/Parent or Guardian Signature Date

_____

Patient Name (Please Print)