Registration & Medical History

CLIENT IDENTIFICATION- Please Print

___MALE ___FEMALE __Mr. __Miss __Mrs. __Ms. __Dr.

Marital Status: ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED ☐ SEPARATED

Last Name	First	MI	Age	Height	Weight	Date of Birth (/ /)	SSN (- -)

Street Address	Apt/Unit/Suite	City	State	Zip Code

Home Phone	Mobile Phone	Business Phone	Email Address

Occupation	Employer's Name	Employer's Address

Emergency Contact	Relation	Home Phone	Mobile Phone

Preferred Method of Contact: ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Text Message ☐ Other_____

Referred By: _____ ***Relation to Referral Source:*** _____

Family Physician: _____ ***Specialist Physician:*** _____

Is this visit due to an accident (ex: car, sports, fall etc...)? ☐Yes No If YES, please answer the following:

Type of accident	Date of Injury

ACKNOWLEDGMENTS:

- I consent to treatment necessary for the care of the above named client.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I allow fax transmittal of my medical records, if necessary.
- I am fully financially responsible for services rendered by SPARK Physiotherapy, LLC and their professional staff.
- I understand that payment of is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of any charges.
- I have read and fully understand the consent for treatment, financial responsibility and essential release of medical information clauses.

X _____ _____
Signature Date

X _____ _____
Parent's Signature (If client is under 18 years) Date

MEDICAL HISTORY QUESTIONNAIRE – Descriptive as possible

Client Name: _____ **Date:** _____ **Left** or **Right** Handed

In your own words, describe what happened and/or what is bothering you: _____
_____
_____

When did this problem begin/how long has it bothered you? _____
Did this problem develop over time or at one instance? _____

Where does it hurt? _____

When does it hurt (which movements/positions)? _____
_____

Describe your pain (i.e. sharp, dull, shooting, aching, etc.): _____

On a scale from 0 *(no pain)* to 10 *(most severe pain)* rate your pain level:
Best/Lowest: _____**/10** ***Right Now:*** _____**/10** ***Worst/Most:*** _____**/10**

What makes your pain better/how do you decrease your pain/get relief? _____
_____

What movements, activities or situations make your pain or issue worse? _____
_____

Have you been treated previously for this condition? Yes No
Where? _____ **When?** _____ **What?** _____ **Effective? Y N**
Where? _____ **When?** _____ **What?** _____ **Effective? Y N**

List any medications you are taking (both over-the-counter and herbal supplements): _____
_____

List any bone, joint, muscle or nerve injury from your past: _____
_____
_____

Circle any of the below conditions that currently or have applied to you:

Heart Conditions/MI	YES	NO	Lyme Disease	YES	NO
Stroke/CVA	YES	NO	Diabetes	YES	NO
High Blood Pressure/HTN	YES	NO	Arthritis	YES	NO
Circulation Issues	YES	NO	Thyroid Problem (Hypo/Hyper)	YES	NO
Kidney or Bladder Disease	YES	NO	Cancer	YES	NO
Hepatitis/Liver Disease	YES	NO	Epilepsy/Seizure/Convulsions	YES	NO
Tuberculosis	YES	NO	Ulcer or Gastro-Intestinal	YES	NO
Asthma/Emphysema/Lung	YES	NO	Allergies	YES	NO
Concussions(s)	YES	NO #__	Neck/Back Pain	YES	NO
Wound Healing Problems	YES	NO	Pregnancy (current/within 12mo)	YES	NO
Mental or Emotional Changes	YES	NO	Other: _____		
Unexpected Body Weight Changes	YES	NO			

What goals would you like to achieve through physical therapy? _____

_____

Our Policies:

We are **dedicated** to providing **highly individualized manual and therapeutic/functional exercise care** for clients with **sports or orthopedic injuries/pain**. Your plan of care is achieved through the professional assessment of your therapist and physician, and is based on your specific needs. **Please carefully read the following policies and sign below**.

1. **Insurance**: We have an excellent record of getting clients reimbursed for their care. In order to achieve the best possible results for our clients and maintain our industry leading standard of care, **SPARK PHYSIOTHERAPY, LLC (SPARK) does not bill third parties for payment**. Payment is expected when services are rendered. Patient is fully responsible for knowledge of his/her own insurance benefits and reimbursement policies. **SPARK will make being reimbursed by your insurance provider as easy as possible providing all necessary records and documentation as needed**.

2. **Automobile Accidents**: We do not bill auto insurance companies nor do we accept assignment on any automobile accident. We do not wait for settlement from attorneys or wait for settlement from any automobile carriers. Reimbursement for care can be obtained in the same way that clients are reimbursed from a health insurance carrier.

3. **Medicare**: We are not Medicare providers, and cannot bill Medicare for you. At this time we cannot accept clients who intend to bill Medicare.

4. **Durable Medical Equipment (DME) and Supplies**: Some DME and supplies are not reimbursable by insurance companies and must be paid for prior to ordering.

5. **Payment**: Payment is **expected when services are rendered** (**each visit**). For your convenience, we can accept payment on a weekly basis. If alternative arrangements are necessary, please contact us directly. We accept VISA, MasterCard, American Express, check and cash. We expect accounts to be paid in full within 30 days from the last day of treatment.

6. **Late Charges/Returned Checks**: Any account that remains open beyond 30 days from last date of treatment will be subject to a $10.00 fee for each month that the account is not paid in full. There is a $35.00 fee for all returned checks.

7. **Cancelled/Missed Appointments**: If a client is more than 15 minutes late for an appointment, SPARK reserves the right to cancel or reschedule the treatment. Late arrivals are subject to the full fee for the session. **We require 24-hour notice for cancellations**. **Appointments that are cancelled with less than 24 hours notice or no show appointments are subject to the full charge of the scheduled appointment**, which is not reimbursable by insurance providers. **Payment information on file will be used to make payments for missed or late canceled appointments; see associated documentation for more information.**

8. **Right to Triage**: SPARK will see each client at their greatest convenience. However, we reserve the right to triage clients on emergency cases.

9. **Fees**: We reserve the right to alter the fee schedule without notice. Please see our latest fee schedule for Initial Evaluations and subsequent therapy sessions. After the initial evaluation, subsequent physical therapy sessions are billed in 15-minute increments and are typically one (1) hour.

10. **Documentation**: The therapist reserves the right to allow documentation time during client treatments.

11. **Consent for Treatment**: The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures as requested by the physician prescribing care and as necessary as evidenced by full evaluation. **Your physical therapist will monitor your progress and adjust your treatment duration and frequency accordingly**.

12. **Our Pledge Regarding Medical Information**: We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at SPARK. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by SPARK PHYSIOTHERAPY, LLC. We are required by law to:
    - Make sure that medical information that identifies you is kept private.
    - Give you this notice of our legal duties and privacy practices with respect to medical information about you.

13. **Student Physical Therapists:** SPARK participates in the education and internship of Student Physical Therapists. The patient has a right to opt out of Student Physical Therapy participation/observation. If you do not wish to have Student Physical Therapist participation in your treatment, please initial here (you may opt back in at anytime with written consent) _____

I have read the above policies and understand that payment is due when services are rendered. I agree to accept full financial responsibility for medical expenses incurred at SPARK PHYSIOTHERAPY, LLC.

If patient is under 18 years of age, and a parent is not able to attend sessions of physical therapy with the minor, the parent(s) signature for authorization allows SPARK PHYSIOTHERAPY, LLC to commence physical therapy treatments with the patient who is a minor. The parent(s) is also accepting full financial responsibility for the treatment.

Client Signature: _____ Date: _____

Parent's Signature: _____ Date: _____
(If client is under 18 years)

Notice of Privacy Practices SPARK PHYSIOTHERAPY, LLC

This notice describes how medical information about you may be used and disclosed, and how you can access this information.

1. Uses and Disclosures of Protected Health Information.
SPARK PHYSIOTHERAPY, LLC will use or disclose your protected health information (PHI) as described in this section. Your PHI may be used and disclosed by SPARK PHYSIOTHERAPY, LLC, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of SPARK PHYSIOTHERAPY, LLC. Following are examples of the types of uses and disclosures your PHI that SPARK PHYSIOTHERAPY, LLC is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This may include doctors, nurses, technicians, other physical therapists, or other providers who have referred you for services or are involved in your care. For example, we may feel that a patient we are treating for chronic low back pain would benefit from an evaluation by a pain specialist to address pharmacological pain management. The health information we share with the pain specialist would be considered a treatment related disclosure.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include the disclosure of health information to your physician, insurance company for certain activities before it approves or pays for the health care services recommended, such as: reviewing services provided to you for medical necessity and undertaking utilization review activities.

Health Care Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of SPARK PHYSIOTHERAPY, LLC. These activities include, but are not limited to, quality assessment activities, employee review activities, training of clinical students and staff, licensing, marketing, and conducting or arranging for other business activities. For example, we may disclose your PHI to physical therapy students treating patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use your name and PHI for patient flow tracking in the office. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment. We will share your PHI with third party business associates that perform various activities such as billing and transcription.

Other Special Uses: SPARK PHYSIOTHERAPY, LLC may use your PHI to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law:
The federal health information privacy regulations neither permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if you are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2. Your Privacy Rights:
Restrictions: You have the right to request restrictions on how your PHI is used. However, we are not required to agree with your request. If we do agree, we must abide by your request. You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI: You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing. Any requests that your medical record be sent to a third party of your choosing must also be made through a written request that clearly identifies the relevant third party and grants express permission to release records to that third party.

Amendments: You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures: You have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints: If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy: We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact: If you would like more information about our privacy practices or to file a complaint you may contact:
Dr. Carlos J. Berio, PT, DPT, MS, CSCS
5712 General Washington Dr. Unit H
Alexandria, VA 22312
cjberio@sparkphysio.com
703-329-0181

I have reviewed and understand the Notice of Privacy Practices for SPARK Physiotherapy, LLC, Inc.

Client Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____
(If client is under 18 years)

SPARK Physiotherapy, LLC Financial Policy

SPARK PHYSIOTHERAPY, LLC operates as an out-of-network provider for most insurance plans. We believe that insurance companies should not dictate the care you receive and in clinics that accept all manner of third party payment, that's exactly what happens. Our clients demand a higher level of customer service and expert care.

In order to maintain our industry leading standards and individualized treatment sessions, SPARK Physiotherapy, LLC will not directly bill or negotiate with insurance companies. In order to decrease the administrative load on our clients so they can concentrate on maximizing their healing and improvement, we at SPARK Physiotherapy have developed a system to submit claims to insurance companies for patient reimbursement. Patients have had great success with reimbursement using the documentation we provide. At this time we cannot accept clients who intend to bill Medicare for services rendered.

Billing
- Payment is expected when services are rendered.
- The patient is responsible for all charges for services provided by SPARK Physiotherapy, LLC.
- Reimbursement documentation can be submitted by SPARK PHYSIOTHERAPY, LLC to insurance companies on a monthly basis unless otherwise specified below.
- Patients may still choose to submit their own insurance claims

FINANCIAL RESPONSIBILITY-If different than Client. (□ *check here for same as above)*

___MALE ___FEMALE __Mr. __Miss __Mrs. __Ms. __Dr.

Last Name | First | MI | Age | Date of Birth (__/__/____) | SSN (___-___-____)

Street Address | Apt/Unit No. | City | State | Zip Code

Home Phone | Mobile Phone | Business Phone | Email Address

Relationship to Client | Address | City | State | Zip

Frequency of Superbill Submission (circle one): Weekly Bi-Monthly Monthly Quarterly

***Cancelled/Missed Appointments**: If a client is more than 15 minutes late for an appointment, SPARK reserves the right to cancel or reschedule the treatment. Late arrivals are subject to the full fee for the session. **We require 24-hour notice for cancellations**. **Appointments that are cancelled with less than 24 hours notice or no show appointments are subject to the full charge of the scheduled appointment**, which is not reimbursable by insurance providers.*

Credit card number: _____-_____-_____-_____ *Exp:*_____ *CVC code:* _____

Address associated with card
*(if different from above):*_____

I have read SPARK Physiotherapy, LLC Financial Policy and understand that the patient is ultimately responsible for all charges for services provided by SPARK Physiotherapy, LLC. I also understand that appointments that are cancelled with less than 24hours notice or no show appointments are subject to full charge.

Client's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____
(If client is under 18 years)