MMA & Sports Rehab
1033 South Edgewood St, Arlington VA 22204
Phone: 703-884-7084
Fax: 571-982-3186

PATIENT INFORMATION

Legal Patient Name _____ Date _____
Address _____
Street *City* *State* *Zip*
Phone _____ Cell _____
Email _____ Birthdate _____
Family Physician _____ Referring Physician _____
Sex ❒ Male ❒ Female ❒ Other Name of Referring Source (friend, relative, ad, etc.) _____
Marital Status ❒ Single ❒ Married ❒ Divorced
Emergency Contact Name _____ Phone _____

ATTENDANCE POLICY

Your success in therapy is a direct result of regular attendance to therapy, communicating openly with your therapist and following your home exercise program. Our clinic has a policy stating that if there are **two** missed appointments, **two** no shows or erratic / inconsistent attendance, the patient may be subject to discharge. In this event and the patient's physician and insurance provider will be notified if you are a worker's compensation patient. All missed visits are documented in the patient's medical record. If you are discharged because of attendance problems, you may be required to obtain a new physician's script for continued physical therapy (if needed).

Twenty-four hours' notice must be given for any cancellation or re-scheduling of appointments. **Failure to give notice before 24 hours will result in a $50.00 cancellation or no-show fee, which will be payable at your next scheduled appointment.** Payment must be made before continuing physical therapy services. Patients must be on time for their scheduled appointment. If you are 15 minutes or more late, you may not be able to be seen and may have to wait until the next scheduled appointment.

I have read the attendance policy and understand that my cooperation and active participation directly relates to the success of my therapy program.

_____ _____
Patient's Initial Date

CONSENT FOR TREATMENT

Patient's Name _____

I hereby authorize the providers at MMA & Sports Rehab to perform the treatments or procedures.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make and guarantees regarding the outcome of any medical treatment or procedure.

I, the undersigned authorize payment of medical benefits to MMA & Sports Rehab for any services furnished me by the provider. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me.

This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient/Authorized Persons Signature Date

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Notice and Acknowledgement

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

Available upon request is a copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience, the following is a summary of the information discussed in the notice.

Your Personal Information
Our Privacy Practices
How We May Use or Share Your Information for

- Treatment
- Payment
- Health Care Operations
- Notifications
- Research
- Marketing only upon your written permission
- Special Circumstances upon your Written Permission

We also have access to Pentagon MMA building and at times, we may perform sports rehab treatments at the building. Pentagon MMA building has video camera which the building use for security purpose only.

Your signature only acknowledges that we have reviewed out privacy practices. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

I hereby acknowledge receipt of the Notice of Privacy Practices.

_____	_____	_____
Signature	Printed Name	Date

Patient Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with MMA & Sports Rehab. In providing us with your credit card information, you are giving MMA & Sports Rehab permission to charge your credit card on file if you fail to pay your co-pay, co-insurance, deductible or cancellation/ no show [or any other patient(s) you have listed on this form]. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays*:* Co-pays/co-insurances/deductibles are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, MMA & Sports Rehab will notify you via phone and/or email or mail. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize MMA & Sports Rehab, to charge co-pays and outstanding balances on my account to the credit card to MMA & Sports Rehab.

Patient's Full Name

Patient's Signature

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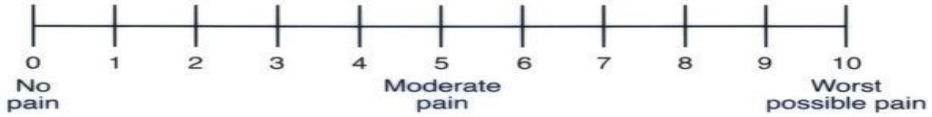
Medical History Form

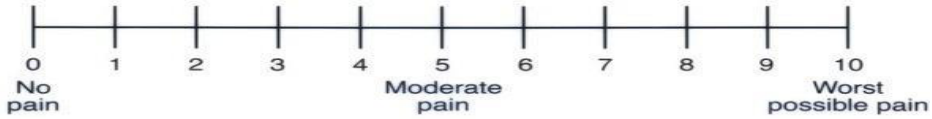
Reason for this visit _____

_____

Using the following scale, with 1 being the least amount of pain and 10 being very severe pain, rate your pain during rest:



Using the same scale, rate your pain during activity:



Indicate the type of pain you feel:

❒ Stabbing ❒ Burning ❒ Aching
❒ Pins and Needles ❒ Numbness ❒ Shooting

Are you presently working? ❒ Yes ❒ No Occupation _____

Any recent significant change in your appetite? ❒ Yes ❒ No

Do you currently experience any of the following?

❒ Cardiac Problems ❒ Diabetes ❒ Hypertension ❒ Cancer
❒ Orthopedic Problems ❒ Rheumatoid Arthritis ❒ Pacemaker ❒ Seizures
❒ Multiple Sclerosis ❒ Fibromyalgia ❒ Drug/Alcohol Dependency
❒ History of Surgery _____

Are you pregnant? ❒ Yes ❒ No

List of Medical Allergies _____

_____

List all prescription or over-the-counter medications you are currently taking _____

_____

Other info: _____