Industrial Health
DEDICATED TO CASE RESOLUTION OF THE INJURED WORKER®

Dear Patient,

An appointment has been made for you with a Physical Therapist or Occupational Therapist. The scheduled time has been reserved for you and cannot be reassigned unless a minimum notice of 48 hours is provided to reschedule your appointment.

If you fail to make your scheduled appointment time, or less than 48 hours notice was provided, the following condition must be met before an appointment can be rescheduled for you:

A fee of $25.00 must be paid before a new appointment can be scheduled.

I have read and understand the above information. I understand that I am responsible for any charges incurred as a result of my failure to provide the required 48 hours notice for not keeping an appointment. I understand that any charges related to canceling or no-showing, will not be billed to my insurance carrier.

Print Name: _____

Signature: _____

Date: _____

Witness: _____

Date: _____

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CREDIT POLICY

Our credit policy is designed to provide a clear understanding that the patient is ultimately responsible for payment of all medical services. Because of our primary responsibility to provide the patient with the best possible medical treatment and to effectively control rising health care costs, we expect payment at time of service for all non-insured patients. Payment of service can be charged to your Visa, Master Card, or Discover credit cards. Industrial Health is very sensitive to situations in which special payment arrangements may be necessary but must be approved by our credit manager before treatment can occur. All unpaid balances not paid in 30 days (except for qualified insurance claims) may be charged a finance charge of 1.5% per month. Insurance copays are due at the time of service for each appointment. If you are not prepared to make your copay, there will be an additional $10.00 fee billed to your account. There will be a $35.00 charge assessed for all returned checks.

I/We assign to Industrial Health all monies entitled to me for the purpose of payment of any unpaid balance resulting from medical treatment received at this facility. I/We further understand that I/We are solely, or together, financially responsible for all charges incurred at this facility but not covered by this assignment, even though represented by an attorney.

Patient's Signature _____ Date _____

Guarantor's Signature _____ Date _____

CONSENT TO HIV/HBV TESTING

In the event a health care provider is directly exposed to my blood or body fluids, I consent to blood tests to determine the presence or absence of antibodies to the Human Immuno-Deficiency Virus (HIV) and the Hepatitis B Virus (HBV). I understand that the test results will become a permanent part of my health care record. The test results may be released to me or my legally authorized representative and the person who was exposed. In addition, the test results can be obtained by my health insurance carrier or by any person or entity to whom I have given written permission for access to my medical record. In certain circumstances your records could be subpoenaed for a court order.

Patient's Signature _____ Date _____

Guarantor's Signature _____ Date _____

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PATIENT REGISTRATION FORM

Date:_____

Billing Information

Person Responsible for Bill: Workers Compensation

Patient Information

Patient's Last Name:_____ First:_____Middle: _____

Address:_____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone# _____ Work Phone#_____Cell Phone#_____

Male ☐ Female ☐ Marital Status S____ M ____ D ____W ____ Spouse Name: _____

Patient Social Security #:_____Date of Birth:_____

Employer:_____ Occupation:_____

Employer Address: _____

Emergency Contact

Emergency Contact Name: _____ Relationship_____

Contact #: ( ) _____-_____

Preferred Method of Communication

Please Circle Cell Home Mail Work Other: _____

How did you hear about us?_____

Workers' Compensation Information

WC Carrier Name: _____ Phone #: _____

Claim #: _____ Date of Injury: _____

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Date: _____ Account #: _____

Referring Physician: (name, address and phone number): _____

Primary Care Physician: (name, address and phone number) _____

_____

Present Complaint: Indicate body part/ Right/Left _____

Date & Time Injury/ Pain occured: _____ Injury Related: ( ) Yes ( ) No Work Related: ( ) Yes ( ) No

Date & Time First seen for this Injury/Pain: _____

List Activities that make it worse: _____

Patient Ethnicity: _____ Patient Race: _____ Patient Language: _____ Declined: _____

Pharmacy of Choice and location: _____

PAST MEDICAL HISTORY

Do any of these Medical Problems below apply to you? Please check box to the left of those that apply.

☐ Anemia	☐ Chest Pain	☐ Heart Attack	☐ Seizures
☐ Anxiety	☐ Depression	☐ Heartburn/Reflux	☐ HIV
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Sleep Apnea
☐ Bleeding Tendency	☐ Dizziness	☐ High Cholesterol	☐ Stomach Ulcers
☐ Blood Clots	☐ Emphysema	☐ High Blood Pressure	☐ Stroke
☐ Cancer	☐ Headaches	☐ Shortness of breath	☐ Thyroid Disease
☐ Chronic Leg Swelling	☐ Hearing Loss	☐ Irregular or Fast Heartbeat	☐ Asthma
☐ Tuberculosis	☐ MRSA	☐ Other:	

If checked any of the above, please describe and give date of each: _____

_____

PAST SURGICAL HISTORY

Please list **ALL** of your previous Surgeries.

Date	Type of Surgery/Body Part	Surgeon

IMMUNIZATION HISTORY

Tetanus: ____within the last 10 years ____ unknown

Hepatitis B: ____childhood ____other (please explain:_____) ____unknown

FAMILY MEDICAL HISTORY

Please indicate the existence of the following conditions in your family and the family member affected.

	Yes	No	Family Member
High Blood Pressure			
Heart Attack			
Stroke			
Diabetes			
Cancer: list below			

SOCIAL HISTORY

Do you currently smoke? ____No ____Yes If yes, Daily usage:_____ Number of years: _____

If no, have you ever smoked? ____No _____Yes

Do you drink alcohol? ____No ____Yes ____Socially If yes, how many ounces/beers per day? _____

Illicit drug use? ____No ____Yes If yes, check drug Marijuana ___ Cocaine ___ Heroin___

ALLERGY

Are you **ALLERGIC** to any **MEDICATIONS**? ____No ____Yes If yes, please list below

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Other Allergies: _____No _____Yes ( ) **Metal ( ) Iodine ( ) Shellfish ( ) Latex**

Other: _____

Have you had any unusual reaction to anesthesia? ____No ___Yes (type of reactions):

MEDICATION HISTORY

Please List **ALL** Medications you are presently taking? (as well as over the counter, herbs, supplements)

Medication	Dosage	Date Started	Prescribing Doctor

Signed by: _____

Patient/Guardian Signature

REVIEWED BY:

(Office use only)

Date	Name	Date	Name

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PATIENT CONSENT

I authorize Industrial Health and/or their administrative and clinical staff to use or disclose the following protected health information:

____ Entire Medical Record ____X-rays ____Other (please specify): _____ ____Declined:

This authorization permits Industrial Health to disclose the specified protected health information to the following person(s), address, or fax:

_____ _____
_____ _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the practice's Privacy officer at 113 Executive Dr, Suite 112 Sterling, VA 20166.. Revocations are not effective until received by the Privacy Officer. The revocation must include the patient's account number, name, address, the date of the original authorization, the recipients of the original authorization, the date of the revocation and the patient's signature. Industrial Health will accept written revocations of this authorization via: U.S. mail, in person, or by fax.
This authorization shall expire two years from the date of signature.

_____ _____
Patient/Guarantor Signature Date

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

As part of my health care treatment, I understand the office may try to contact me by phone. *Please initial the following:*

- It ☐ is/ is not ☐ acceptable to leave a message regarding my protected health information including test(s) results on my answering machine.
- It ☐ is/ is not ☐ acceptable to leave a message regarding my protected health information including test(s) results with a member of my household.
- It ☐ is/ is not ☐ acceptable to discuss my protected health information with the emergency contact person that I have listed in the event that the office cannot reach me at the home/work number(s) that I have provided.
- It ☐ is/ is not ☐ acceptable for a member of my household to pick up my written prescription.

I fully understand and accept / decline the terms of this consent.

_____ _____
Patient/Guarantor Signature Date

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I_____ authorize Industrial Health and/or their administrative and clinical staff to use or disclose the following protected health information: Please initial the appropriate section of your protected health information that you are requesting.

____ Entire Medical Record ____ Lab and/or X-ray Results ____Most Recent Office Note

____Demographic Information ____Other (please specify) _____

____X-rays: ____Cervical Spine ____Thoracic Spine ____Lumbar Spine ___Pelvis ____Shoulder ____Humerus

____Forearm ____Wrist ____Hand ____Hip ____Femur ___Knee ____Tibia/Fibula ____Ankle____ Foot _____Other

This authorization permits Industrial Health to send the specified protected health information to the following address or fax:

_____ _____

_____ _____

_____ _____

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Industrial Health 113 Executive Drive, Suite 112, Sterling, VA 20166 . Revocations are not effective until received by the Privacy Officer. The revocation must include the patient's account number, name, address, the date of the original authorization, the recipients of the original authorization, the date of the revocation and the patient's signature. Industrial Health will accept written revocations of this authorization via: U.S. mail, in person, or by fax (571) 375-2856.

This authorization shall expire two years from the date of signature.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Personal Representative's Authority

_____
Description of Personal Representative's Authority

For Office Use Only:

Mailed _____

Faxed on: _____

Picked up by:

Patient _____

Other, Name: _____

Employee Signature:

_____

Patient Account Number: _____