



# Core Wellness & PHYSICAL THERAPY

P: 571-403-2673 F:571-366-2052

## New Patient Registration

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (home) : \_\_\_\_\_ cell: \_\_\_\_\_

May we leave messages at the numbers above? Yes / No

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email address: \_\_\_\_\_

Primary Care Physician or Practice name (Required): \_\_\_\_\_

Referring physician phone number: \_\_\_\_\_

Referring physician email or Fax : \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone number: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

How did you find Core Wellness & Physical Therapy? \_\_\_\_\_



# Core Wellness & PHYSICAL THERAPY

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## Past Medical History and Current Concerns

Name: \_\_\_\_\_ Male\_\_\_ Female\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs

Occupation: \_\_\_\_\_ General Health: Excellent\_\_\_ Good\_\_\_ Fair\_\_\_ Poor\_\_\_

Dietary Habits: \_\_\_\_\_ Exercise: \_\_\_\_\_

Smoking: Yes / No Alcohol: Yes / No If yes, how many drinks per day\_\_\_ per week\_\_\_ occasional\_\_\_

Medical conditions: \_\_\_\_\_

Medications: \_\_\_\_\_

Assistive Devices: None\_\_\_ Cane\_\_\_ Walker\_\_\_ Hearing aids\_\_\_ Glasses\_\_\_

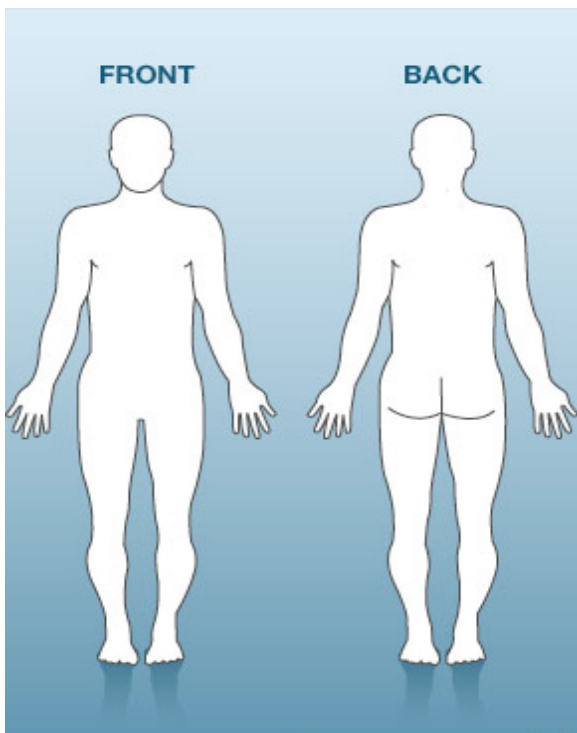
Past Injuries/Surgeries with dates: \_\_\_\_\_

Medical Tests: X-ray\_\_\_ MRI\_\_\_ CT scan\_\_\_ Bone density\_\_\_ EMG\_\_\_ Blood test \_\_\_ Urinalysis\_\_\_ Other

Tests/Results: \_\_\_\_\_

Where do you feel it?

Describe your symptoms:



Blank area for describing symptoms.

Pain level in the last week (circle): No pain Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain? Dull Achy Sharp Numb Tingling **Other:**

When did your symptoms start? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

How did your symptoms develop? Injury (explain): \_\_\_\_\_ date: \_\_\_/\_\_\_/\_\_\_

Surgery (type): \_\_\_\_\_ date: \_\_\_/\_\_\_/\_\_\_\_\_ Unknown cause \_\_\_\_\_

Have you received other treatment for your current condition? Yes / No

If yes, what type of treatment? \_\_\_\_\_ Was it helpful? Yes / No

Have you ever had this condition before? Yes / No If yes, when? \_\_\_\_\_

Did you receive treatment for prior episodes? Yes/ No

If yes, what type of treatment? \_\_\_\_\_ Was it helpful? Yes / No

What makes your symptoms worse? \_\_\_\_\_

What eases your symptoms? \_\_\_\_\_

What are your goals/expectations for physical therapy? \_\_\_\_\_

What daily activities are affected most by your current symptoms?:

- 1.
- 2.
- 3.
- 4.
- 5.



# Core Wellness & PHYSICAL THERAPY

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## Practice Policies

### NEW PATIENTS

**Core Wellness & Physical Therapy is a Direct Access physical therapy provider. This means that you do not need a prescription to be evaluated and for us to initiate treatment.**

If you have a valid prescription, please bring it with you in addition to your completed past medical history forms. If you do not have the forms filled out prior to your evaluation, please come 15 minutes early to complete them, so we may begin at the scheduled appointment time.

### RETURNING PATIENTS

Please bring a new prescription if you were referred, and update appropriate areas of your intake forms to describe your current concerns/symptoms.

### FEES/PAYMENTS

Payment is required at the time services are rendered. For your convenience, we accept cash, credit cards and checks. Core Wellness & Physical Therapy, LLC reserves the right to charge an additional \$50.00 for each returned check.

### INSURANCE REIMBURSEMENT

We will provide you with an invoice or universal health form (HCFA-1500) to submit to your insurance company for reimbursement. We suggest that you contact your health insurance company before your first visit and use our Patient Insurance Worksheet to get the information you need to maximize your out-of-network benefits. The worksheet is provided to help you ask the right questions. It is your responsibility to understand your health insurance coverage, know how to get reimbursed and at what level. Wellness and Pilates services are not reimbursable by insurance when utilized outside of a physical therapy treatment.

### PRESCRIPTION/PHYSICIAN REFERRAL

Please bring a valid prescription (within 30 days), from a licensed physician (M.D or D.O), nurse practitioner, chiropractor, or dentist. **WITHOUT A PRESCRIPTION:** The State of Virginia allows an unlimited number of visits within the first 14 business days following your initial evaluation. We will send your plan of care to your specified primary care provider, and their signature on that document is equal to a prescription. Your insurance company may require a prescription or a copy of the signed plan of care before they provide coverage. If Medicare is your insurance provider, we will be happy to recommend clinics that are covered. You also have the option not to submit for reimbursement.

### TREATMENT SESSIONS

A session typically lasts for one hour. This includes 45-50 minutes of evaluation and/or treatment, and 10-15 minutes for printing out home exercises, payment and scheduling. Half hour sessions will end within 20-25 minutes. Wear or bring clothes are appropriate for exercise and that allow for the torso, arms and legs to be exposed for assessment (shorts, yoga pants or sweat pants and tee-shirt, sports bra or tank top).

### CONSENT TO TREAT

The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures as requested by the physician prescribing care and/or via direct access and subsequent approval of the patients primary care provider. The therapist will monitor progress and adjust treatment frequency and duration according to medical necessity as needed.

### MEDICAL RECORDS

We understand that your present and past medical information is personal. We are committed to protecting information about you. We create a record of care and services you receive at Core Wellness & Physical Therapy, LLC that is maintained electronically via WebPT. This allows for us to remain free of paper charts, that are prone to damage, loss, or security concerns. We need these records to provide you with quality care, to comply with legal requirements and to meet your needs for reimbursement. This notice applies to all of the records generated: law to requires us:

- a. Make sure that medical information that identifies you is kept safe and secure in a HIPPA compliant manner.
- b. Give you this notice of our legal duties and privacy practices with respect to medical information about you.

### NEWSLETTER & CONTACT

If you supplied an email address, you will be signed up for our email newsletter. This will include updates, news, classes, deals, presentations and the like. If you do not wish to receive these, please initial here:

### TARDINESS

We ask that you arrive on time for your appointments and that you are considerate of the next patient's time when your session ends. If you arrive late, your treatment time will be shortened, and you will be responsible for payment of the full visit.

**CANCELLATION/NO SHOW**

Please give us 24 hours notice if you are unable to keep your appointment. Failure to give 24 hours notice will result in a \$100.00 charge to your credit card on file. No shows will also result in a \$100.00 charge. When openings are available, and you are able to reschedule your visit within the same business week, the fee will be waived. It is the patients responsibility to contact us via email AND phone.

**TRIGGER POINT DRY NEEDLING**

Trigger point dry needling may be recommended as part of your physical therapy treatment. It is your choice to receive this modality or defer it. Dry needling is an effective physical therapy modality used in conjunction with other interventions in the treatment of myofascial pain and dysfunction. A solid filament needle is inserted into the skin and muscle directly at a myofascial trigger point. A trigger point consists of multiple contraction knots, which are related to the production and maintenance of the pain cycle. The benefit of dry needling is that it precisely deactivates the trigger point, leading to biochemical changes that reduce pain. Risks of dry needling include, but are not limited to post needling soreness, allergic reaction, vasodepressive syncope (feeling faint), nerve injury, vascular injury, penetration of a visceral organ, increased spasm, muscle edema, infection, and hematoma. Precautions are taken to avoid all of these complications. Acupuncture disclaimer: Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. You should understand that this technique should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment.

**By signing below, I certify that I have read the above policies, understand and will comply with them. I agree that Core Wellness & Physical Therapy, LLC retains the right to charge my credit card for scheduled appointments missed by lateness, late cancellation or no-show activity, as described above.**

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**SIGNATURE**

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**DATE**

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**PRINTED NAME**

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# Core Wellness & PHYSICAL THERAPY

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## Late Cancellation Credit Card Information:

Name of Patient: \_\_\_\_\_

Type of Credit Card: MasterCard Visa American Express Discover Other:

Name as it appears on the card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Security Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City/ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Best contact phone number: \_\_\_\_\_

Best contact email \_\_\_\_\_

By signing below I agree to charges on this credit card for missed treatment sessions and late/cancellation fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please note: This information is protected within your HIPPA compliant electronic medical record.



# Core Wellness & PHYSICAL THERAPY

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## Patient Insurance Worksheet

Core Wellness & Physical Therapy, LLC is an out of network provider. We do, however, offer guidance on how to manage your out-of-network benefits. We suggest that prior to your first visit you contact your insurance company to confirm your coverage benefits. This form serves as a checklist to help you get all the necessary information in order to maximize your reimbursement.

### WHAT TO ASK YOUR INSURANCE COMPANY:

What is my deductible for the year?

Have I paid my out of pocket responsibility yet for this calendar year? Y N If not, how much do I have remaining?

When does my deductible calendar year start over?

What percentage of out of network physical therapy is covered?

Can you tell me what the reimbursable rate is for the following codes?

CPT Code	Procedure	Amount Reimbursable
97161 97162 97163	Initial Examination: Low Complexity Moderate Complexity High Complexity	
97110	Therapeutic Exercise	
97112	Neuromuscular Re-Education	
97140	Manual Therapy	
97530	Therapeutic Activity	
97535	Self Care/Home Management	

Is the percentage of out of network coverage an additional deduction, or has it already been included in the amount reimbursable?

### WHAT TO DO WITH THE INFORMATION:

Once you have received the information regarding "Amount reimbursable" to you by your insurance company it is easy to determine what your reimbursement check should look like. \*The codes provided are those we use with greatest frequency.

1. For each session, you will receive between 2-4 "units" of each code, depending on the length of session
2. For each unit on your invoice, you multiply that number by the amount reimbursable for that CPT code.
3. Add up the total. The total or a percentage of that total (insurance dependent) is what you should expect in the form of a reimbursement check.

**I understand that I am responsible to obtain accurate information about my insurance policy in order to maximize my benefits. I also understand that I will pay for services at the time they are rendered and it will be my responsibility to seek reimbursement. Core Wellness & Physical Therapy, LLC will provide documentation, such as evaluations and progress notes to assist you in this process.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_