Metro Physical Therapy & Chiropractic Center, LLC

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

Today's Date:

Last Name, First Name | Middle Initial

Date of Birth | Marital Status

Street Address

City | State | Zip

Cell Phone | Home Phone

Emergency Contact Name / Number

Is your condition as a result of:

- ☐ Auto Accident
- ☐ Work Injury
- ☐ Other:

Date of Injury: | State

Insurance Information

Primary Insurance | Secondary Insurance

Insured Information (The actual policy holder, if not yourself)

Insured First Name | Insured Last Name

Insured's Date of Birth | Relationship to the Patient

Street Address

City | State | Zip

Chief complaint:

When did you first feel the problem you are having now?

Any prior episode? if yes please explain:

What makes you feel better?

What makes you feel worse?

Does your pain radiate to another part of your body?

Are your symptoms constant or do they come and go?

Have you ever had physical therapy or chiropractic care before?

Any previous broken bones, dislocations or muscle / ligament tears?

Any prior automobile accidents or work related injuries?

Any surgeries or metal inside the body? Pace makers?

Any previous X-rays or MRI studies?

Are you currently receiving any type of treatment for this condition from another provider?

In the past 3 days, from 0 to 10, what was the lowest and highest pain level you experienced?

PATIENT'S AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL RECORDS

I authorize the release of my medical records, including but not limited to any MRI studies or X-ray reports to be forwarded to Dr. Arash Sarabi, D.C. via fax, email or U.S. mail. If you do not want us to discuss your medical information including your appointment time and date with anyone including your spouse or your family members please let us know at this time.

INFORMED CONSENT TO RECEIVE CHIROPRACTIC / PHYSICAL THERAPY SERVICES

PHYSICAL THERAPY, MASSAGE AND CHIROPRACTIC MANIPULATIONS MAY CAUSE AGGRAVATION OF YOUR SYMPTOMS OR INJURIES TO OTHER AREAS OF YOUR BODY INCLUDING SPRAINS, STRAINS, NEUROLOGICAL AND VASCULAR INJURIES INCLUDING STROKE OR EVEN DEATH. Therefore, it is very important to let the doctor know about these conditions BEFORE the treatments are rendered. This way, the doctor can rule out any risk factors and determine the most appropriate treatment plan. These conditions may include:
¨Pregnancy ¨Pacemakers ¨Heart Disease ¨Respiratory Disease ¨Osteoporosis (loss of bone density) ¨Recent Fractures ¨Recent Dislocations ¨Metal Inside the Body ¨Allergies to Shellfish, Latex or Sulfides

Other Options:
There are other options available to you other than chiropractic care, which may be beneficial to you and your condition. These treatment options may include surgery, medication and drug therapy.

Risks of Not Being Treated:
The risks of not receiving treatment may include permanent loss of function, strength, sensation, increased pain and joint degeneration.

Referrals and Recommendations:
Treatment of your condition may require referrals to specialists and/or diagnostic procedures such as X-rays or MRI studies. Follow-up with these recommendations and referrals are the patient's responsibility. Not following with the recommended treatment plan and/or missing your scheduled treatment sessions will be interpreted as withdrawal from care against doctor's advice. I have carefully read and understand the above information and am fully aware of what I am signing. I understand that I may ask the doctor for a more detailed explanation.

By checking "Agree" I do hereby voluntarily consent to be evaluated and to receive massage therapy, physical therapy and chiropractic treatments.

◯ I agree.

◯ I do not agree.

_____

	Please Mark All that Apply	Taking Medication for this Condition
Pregnancy	◯	◯
Pacemakers	◯	◯
Heart Disease	◯	◯
Respiratory Disease	◯	◯
Osteoporosis	◯	◯
Stroke	◯	◯
Fractures	◯	◯
Recent Dislocations	◯	◯
Metal Inside the Body	◯	◯
Muscle / Ligament Tear	◯	◯
Surgeries	◯	◯
Aneurysm	◯	◯
Disc Bulge / Herniation	◯	◯
Blood Clots	◯	◯
Dizziness / Vertigo	◯	◯
Numbness / Tingling	◯	◯
Headaches	◯	◯
Neck Pain	◯	◯
Upper Back Pain	◯	◯
Lower Back Pain	◯	◯
Shoulder Pain	◯	◯
Elbow Pain	◯	◯
Hand / Wrist Pain	◯	◯
Hip Pain	◯	◯
Knee Pain	◯	◯
Ankle / Foot Pain	◯	◯

Self and Family Health History - Please Mark All that Apply

Diabetes	☐ Self	☐ Family	☐ Now	☐ Before
Liver Disease	☐ Self	☐ Family	☐ Now	☐ Before
Pancreas Disorder	☐ Self	☐ Family	☐ Now	☐ Before
High Cholesterol	☐ Self	☐ Family	☐ Now	☐ Before
High Blood Pressure	☐ Self	☐ Family	☐ Now	☐ Before
Mental Health Issues	☐ Self	☐ Family	☐ Now	☐ Before
Depression	☐ Self	☐ Family	☐ Now	☐ Before
Anxiety	☐ Self	☐ Family	☐ Now	☐ Before
HIV / AIDS	☐ Self	☐ Family	☐ Now	☐ Before
Limes Disease	☐ Self	☐ Family	☐ Now	☐ Before
Overweight	☐ Self	☐ Family	☐ Now	☐ Before
Underweight	☐ Self	☐ Family	☐ Now	☐ Before
Eating Disorder	☐ Self	☐ Family	☐ Now	☐ Before
Insomnia	☐ Self	☐ Family	☐ Now	☐ Before
Loss of Vision	☐ Self	☐ Family	☐ Now	☐ Before
Hearing Loss	☐ Self	☐ Family	☐ Now	☐ Before
Incontinence	☐ Self	☐ Family	☐ Now	☐ Before
Erectile Dysfunction	☐ Self	☐ Family	☐ Now	☐ Before
Neurological Disorder	☐ Self	☐ Family	☐ Now	☐ Before
Conditions of the Skin	☐ Self	☐ Family	☐ Now	☐ Before
Gastrointestinal Problems	☐ Self	☐ Family	☐ Now	☐ Before
Allergies to Medication	☐ Self	☐ Family	☐ Now	☐ Before
Cancer	☐ Self	☐ Family	☐ Now	☐ Before

Any Other Health Related Issues We Should Know About?

Hobbies, Recreation and Related Activities

Have Your Hobbies, Recreation & Related Activities Changed Because of Your Condition?

Job Description and Work Activities

Has Your Job Description and Work Activities Changed Because of Your Condition?

Have You Lost any Income as a Direct Result of Your Condition?

Any Changes in House Chores and Domestic Duties because of Your Condition?

Smoking ☐ Never ☐ <1 pack /day ☐ 1-2 packs /day

Alcohol ☐ Never ☐ 1-2 drink /day ☐ 2-3 drinks /day

Caffeine ☐ Never ☐ 1-2 cups ☐ 2-3 cups ☐ >3 cups

Exercise ☐ Daily ☐ 1 x week ☐ 2 x week ☐ Never

Food and Drug Allergies

Medication List

Oswestry Lower Back Pain Questionnaire

Please Complete this Form Only if You Suffer From Lower Back Pain

Use the drop down menu to pick the most correct answer to each question:

Pain Intensity

Lifting

Sitting

Personal Care (Washing, Dressing, etc.)

Walking

Standing

Sleeping

Traveling

Social Life

Changing Degree of Pain

NOTICE OF PRIVACY PRACTICE AND CONFIDENTIALITY OF HEALTHCARE INFORMATION

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us.
We have the following duties regarding the maintenance, use and disclosure of your health records:
(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information. (2) We are required to abide by the terms of this Notice currently in effect. (3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.
There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.
We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.
Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an EMERGENCY TREATMENT SITUATION. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

You have certain rights regarding your health record information, as follows:
(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. (2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. (3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. (4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion. (5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period. (6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to PRIVACY OFFICER:

Dr. Arash Sarabi, D.C.

THIS FORM MUST BE COMPLETED FOR ANYONE WHO HAS MEDICARE.
PLEASE ASK FRONT DESK FOR HELP.

***(A)* Notifier(s):**
***(B)* Patient Name:** ***(C)* Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)*_____** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D)*_____** below.

***(D)*_____**	***(E)* Reason Medicare May Not Pay:**	***(F)* Estimated Cost:**
New Patient Evaluation	Medicare does not pay for new patient evaluation done by chiropractors.	70.00 to 120.00
Physical Therapy	Medicare does not pay for physical therapy done by chiropractors.	35.00 to 60.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***(D)*_____** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

***(G)* OPTIONS:** **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the ***(D)*_____** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the ***(D)*_____** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the ***(D)*_____** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

***(H)* Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**