Collaborative Physical Therapy, PLLC
Postural Restoration Center, Certified

Karen Taylor Soiles, PT, MA, PRC
703-646-0313 phone • 571-550-9607 fax
karen@collaborativept.com
www.collaborativept.com

IMPORTANT INFORMATION FOR FIRST VISIT

LOCATION

Collaborative Physical Therapy is located at
4001 9th Street North, Suite 230
Arlington, VA 22203

We are in The Teal Center in Randolph Towers, two blocks from the Ballston Metro and off of the Glebe Road exit on I-66.

PARKING AND ENTRANCE

There is metered parking on 9th Street North or free parking in the rear lot of Randolph Towers.

To park in the Randolph Towers lot, pull into the circular drive at the front of the building, park your car there for a moment and go in to the front desk. Tell them you are coming to The Teal Center and they will give you a token and a parking pass. Note: The entrance to the lot is on Quincy Street. Turn left out of the driveway on 9th Street and then left on Quincy. Then make your next left into the surface parking lot.

We are on the second floor of Randolph Towers in The Teal Center. Take the stairs up from the lobby or the elevators that are located down the hall to your right as you enter the front door. On the second floor, walk to your left and you will find us at the end of the corridor.

WHAT TO WEAR

It is helpful to wear loose fitting exercise shorts or pants if you are coming for a lower body/back issue. For ladies, bring a camisole or tank top for back, neck or upper body issues.

WHAT TO BRING

Please bring your completed registration forms and doctor's authorization if you have one. Please also bring any mouth guard or foot orthotics you have to your appointment.

CANCELLATION OR RESCHEDULING

Please provide at least 24 hours notice if you need to cancel or reschedule your appointment. You may do so by calling 703-646-0313 between 9am-5pm or emailing me at karen@collaborativept.com.

See you soon!

Karen

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PATIENT REGISTRATION INFORMATION

Please print information and present ID and insurance cards Date _____

Last Name_____ First _____ Middle _____

Address_____

City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

Phone: Cell _____ Home _____ Business _____

Marital status □ single □ married □ divorced □ separated □ widowed

Email address(es) _____

Appointment reminder □ email □ text □ call □ *check if you DO NOT give consent to leave a voice message*

Referred by_____

Occupation _____ Employer _____ Address _____

Emergency Contact _____ Relation_____ Phone_____

Primary Care Provider _____ MD ____ DO ____

Specialty/Name of Practice _____

Address_____

Phone _____ Fax _____

Referring Practitioner _____

Specialty/Name of Practice _____

Address_____

Phone _____ Fax _____

Sign _____

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MEDICAL HISTORY

Patient Name _____ Date of Birth _____

EXISTING OR RELEVANT PREVIOUS CONDITIONS – please check if applicable

Allergies	○ Yes ○ No	Dizzy Spells	○ Yes ○ No	MRSA	○ Yes ○ No
Anemia	○ Yes ○ No	Emphysema/Bronchitis	○ Yes ○ No	Multiple Sclerosis	○ Yes ○ No
Anxiety	○ Yes ○ No	Fibromyalgia	○ Yes ○ No	Muscular Disease	○ Yes ○ No
Arthritis	○ Yes ○ No	Fractures	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Asthma	○ Yes ○ No	Gallbladder Problems	○ Yes ○ No	Parkinsons	○ Yes ○ No
Autoimmune Disorder	○ Yes ○ No	Headaches	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No
Cancer	○ Yes ○ No	Hearing Impairment	○ Yes ○ No	Seizures	○ Yes ○ No
Cardiac Conditions	○ Yes ○ No	Hepatitis	○ Yes ○ No	Smoking	○ Yes ○ No
Cardiac Pacemaker	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Speech Problems	○ Yes ○ No
Chemical Dependency	○ Yes ○ No	High/Low Blood Pressure	○ Yes ○ No	Strokes	○ Yes ○ No
Circulation Problems	○ Yes ○ No	HIV/AIDS	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Currently Pregnant	○ Yes ○ No	Incontinence	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Depression	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Vision Problems	○ Yes ○ No
Diabetes	○ Yes ○ No	Metal Implants	○ Yes ○ No		

Please list any other conditions _____

CURRENT MEDICATIONS – list or attach copy

Medication Name	Dosage	Frequency	Purpose of Medication

SUPPLEMENTS

Supplement Name	Dosage	Frequency	Purpose of Supplement

SURGICAL HISTORY

Body Region	Surgery Type	Date

FALL HISTORY – please answer Yes or No

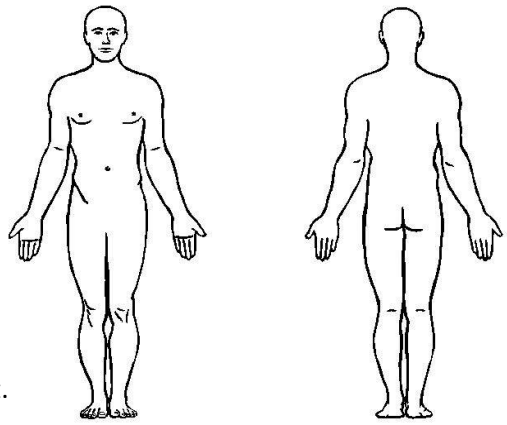
Is this injury a result of a fall in the past year? _____ Have you had 2 or more falls in the past year? _____

Do you feel at risk for falls? _____

DIETARY HABITS – please indicate what you typically consume within each category

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages please include alcoholic, non-alcoholic and water	

PATIENT-SPECIFIC FUNCTIONAL SCALE



Height*_____ Weight* _____

(*required by Medicare)

On the pictures to the right, please indicate the location of your issues.

On the scale below, please indicate your level of discomfort at its worst and best.

0 1 2 3 4 5 6 7 8 9 10

0 = No discomfort 10 = Extreme discomfort

Please identify up to 3 activities that you are unable to do or are having difficulty with (i.e., getting dressed, walking your dog, yard work, sports, etc.).

Activity	Score	✔ Most Limited

Please score each activity using the scale below:

0 1 2 3 4 5 6 7 8 9 10

Able to perform activity at the same level as before problem

Unable to perform activity

Signature _____

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PRACTICE POLICIES

New Patients: If you have a valid prescription from your doctor, please bring it with you as well as your completed forms from our website. If you do not have the forms filled out prior to your visit, please arrive 15 minutes early, so we may begin at the scheduled time.

Returning Patients: Please bring new prescription if you were referred; update all information upon arrival for optimal care.

Prescription/Referral: None needed for first 30-day treatment period. After 30 calendar days per Virginia law, if the episode of care is to continue, a referral is required from your doctor (MD or DO), nurse practitioner, chiropractor or dentist. Insurance coverage varies, so it is the patient's responsibility to check the specifics of his/her plan. *Note: Medicare requires a referral for ALL visits.*

Fees/Payment: Payment is required at the time services are rendered. Checks and debit cards are preferred, but credit cards or cash are accepted. Collaborative Physical Therapy reserves the right to charge an additional $50 for each returned check.

Insurance: Collaborative Physical Therapy is an out of network provider. We will provide you with an invoice to submit to your insurance company for reimbursement. We strive to help you in any way we can to assist with your reimbursement process dictated by your health insurance policy. We strongly recommend you contact your insurance company before your first visit to be best informed about your coverage. Our very best professional services are rendered to you, not to your insurance company. Therefore, payment is your responsibility. You always have the right not to submit for reimbursement.

Medicare: At this time, Collaborative Physical Therapy is no longer accepting new Medicare patients. Any established Medicare patients will continue to be seen.

Treatment Sessions: Wear or bring clothes that allow for full movement (shorts, loose pants, t-shirt, sports bra, tank tops or camisoles are all good choices) Supportive footwear is a must. A session typically lasts for one hour — consisting of 50 minutes of evaluation and treatment and 10 minutes of summary, education and printing out or emailing home program references.

Tardiness: We ask that you arrive on time for your appointments. If you arrive late, your treatment will be shortened and you will be responsible for payment of the full visit.

Cancellation/No Show: Collaborative Physical Therapy places a tremendous value on the time to work thoroughly and individually with each patient. For this reason, 24 hours' notice is required prior to your appointment if cancellation is necessary. Any missed appointments or cancellations with less than 24 hours' notice will result in a fee of $75. Exceptions will be made at the discretion of Collaborative Physical Therapy.

Printed Name

Signature Date

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MEDICALLY INFORMED CONSENT
ASSIGNMENT AND RELEASE

I voluntarily consent to physical therapy treatment for the above named client and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at Collaborative Physical Therapy, PLLC. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that being used to retrain, recruit and restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how she is trying to achieve them. This consent shall be ongoing for a period valid for one year from date listed below.

- I certify all the information provided is correct and true to the best of my knowledge.
- I will be responsible for payment of services at each visit, unless other definitive financial arrangements have been made prior to treatment.
- I understand that Collaborative Physical Therapy, PLLC is an out-of-network provider (does not bill or accept insurance, with the exception of Medicare). Collaborative Physical Therapy, PLLC will provide documentation to assist in obtaining full coverage.
- If I am covered by Medicare, I request payment be made to Collaborative Physical Therapy, PLLC for any services or goods rendered by Collaborative Physical Therapy PLLC. I authorize release of medical information about me to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services to Collaborative Physical Therapy PLLC. I also authorize payment of benefits from my secondary insurance carrier, if applicable, to Collaborative Physical Therapy, PLLC.
- I authorize the release of all medical records to the referring and family physician and to my insurance company, if applicable.
- I allow fax transmittal of my medical records, if necessary.
- I agree to pay all reasonable attorney fees and collection of costs in the event of default of payment of my charges.
- I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.
- I permit a copy of this authorization to be used in place of the original.
- This authorization may be revoked by me, in writing, at any time.

Acknowledgement of Receipt of Notice, Privacy Practices
Collaborative Physical Therapy, PLLC

I hereby acknowledge that I have been provided a copy of this medical practice's Notice of Privacy Practices.
Karen Taylor Soiles, Privacy Officer

Printed Name

Signature Date

If not signed by patient, relationship to patient:
□ parent or guardian of minor patient
□ guardian or conservator of an incompetent patient
□ beneficiary or person representing deceased patient