

## **MOUNT VERNON REHABILITATION AND MEDICINE ASSOCIATES**

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# We are Physiatrists!

Physiatrists, better known as rehabilitation physicians, are nerve, and bone experts who treat injuries or illnesses that affect how you move.

Rehabilitation physicians are medical doctors who have completed training in the medical specialty of physical medicine and rehabilitation (PM&R). Specifically, rehabilitation physicians.

- Diagnose and treat pain
- Restore maximum function lost through injury, illness or disabling conditions
- Treat the whole person, not just the problem area
- Lead a team of medical professionals
- Provide non-surgical treatments
- Explain your medical problems and treatment/prevention plan

The job of a rehabilitation physician is to treat any disability resulting from disease or injury, from sore shoulders to spinal cord injuries. The focus is on the development of a comprehensive program for putting the pieces of a person's life back together after injury or disease-without surgery.

Rehabilitation physicians take the time needed to accurately pinpoint the source of an ailment. They then design a treatment plan that can be carried out by the patients themselves or with the help of the rehabilitation physician's medical team. This medical team might include other physicians and health professionals, such as neurologist, orthopedic surgeons, and physical therapists. By providing an appropriate treatment plan, rehabilitation physicians help patients stay as active as possible at any age. Their broad medical expertise allows them to treat disabling conditions throughout a person's lifetime.

We provide services for patients with:

- Musculoskeletal/Spine problems
- Brain injury Trauma
- Spinal Cord Injury
- Neurological Disorders
- Amputation Rehabilitation
- Stroke Rehabilitation/Inpatient Rehab
- Orthopedic Trauma
- Work Related and Sports Injuries (Concussions)
- General Medical Rehabilitation
- EMG & Nerve Conduction Studies
- Injectable Medicine for Spasticity (Botox or Xeomin)
- Neurotoxin injections for Migraine Headaches
- Telemedicine Services
- Independent Medical Evaluations (IME)

# Mount Vernon Rehabilitation Medicine Associates

## New Patient Registration Form

**Patient Last name:** \_\_\_\_\_ **First name:** \_\_\_\_\_ **MI:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **Sex:**  Male  Female  
**Marital Status:**  Single  Married  Divorced  Widowed  Partnered  Separated  
**Home address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home phone:** \_\_\_\_\_ **Work phone:** \_\_\_\_\_ **Mobile phone:** \_\_\_\_\_  
**Email address:** \_\_\_\_\_ **Preferred Language:**  English  \_\_\_\_\_  
**Race:** \_\_\_\_\_ **Ethnic Background:** \_\_\_\_\_ **Place of Birth:** \_\_\_\_\_  
**Emergency contact person:** \_\_\_\_\_ **Contact phone #:** \_\_\_\_\_

<b>Who referred you to our office?</b> _____ <b>Who is your primary care provider?</b> _____	<b>Preferred Pharmacy:</b> _____ <b>Location:</b> _____ <b>Phone # (if known):</b> _____
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**Insurance Information:**

	Primary Insurance	Secondary Insurance (if applicable)
<b>Carrier</b>		
<b>Name of policy holder (if different)</b>		
<b>Policy Number</b>		
<b>Group Number</b>		
<b>Address</b>		

**Worker's Compensation Information (if applicable):**

<b>Date of injury:</b>	<b>Case Manager Name:</b>
<b>Claim Number:</b>	<b>Case Manager Phone:</b>
<b>Insurance Company:</b>	<b>Case Manager Fax:</b>

**Consent regarding payment/insurance:**

I hereby authorize Mount Vernon Rehabilitation Medicine Associates to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of all information necessary to secure payment of benefits to my insurance company or health care program.

I understand that I am financially responsible for any and all charges on my account whether or not paid by my insurance plan.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Mount Vernon Rehabilitation Medicine Associates

## Reason for Visit

Please describe the symptoms that have brought you to our office:

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When did this problem begin: \_\_\_\_\_

Did your problem begin after an injury?  Yes  No

If yes, is this injury related to:  Work  School  Motor vehicle crash  Sport

Please describe how the injury occurred in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any prior evaluation of this problem?  Yes  No

If yes:  Physical examination  X-ray  CT scan  MRI  EMG

Other \_\_\_\_\_

When was this completed? \_\_\_\_\_ Where? \_\_\_\_\_

Have you had any of the following treatments for your current problem?

Physical therapy  Chiropractor  Injections  Surgery

Medications (please list):

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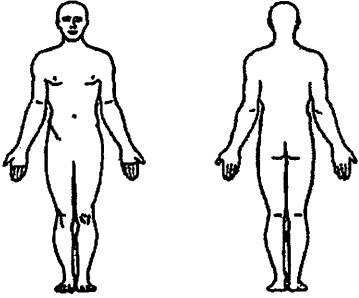
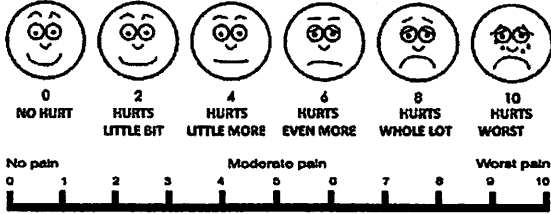
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Helped  Didn't help  Had adverse effect  
 Helped  Didn't help  Had adverse effect  
 Helped  Didn't help  Had adverse effect

What makes your current problem better? \_\_\_\_\_ Worse? \_\_\_\_\_

Do you have any pain today?  Yes  No

If yes:

<p><b>Please indicate where you have pain</b></p>  <p>_____</p>	<p><b>Please rate your pain on a scale of 0 to 10</b></p>  <p>_____</p>
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What is your current Height and Weight: \_\_\_\_\_ Feet \_\_\_\_\_ Inches \_\_\_\_\_ Pounds

# Mount Vernon Rehabilitation Medicine Associates

## Medical History

**Past Medical History:** Have you ever had any of the following conditions? (Check all that apply)

- |                                       |  |   |   |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Brain injury      | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Anxiety      | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> COPD              | <input type="checkbox"/> Insomnia       | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Depression        | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Blood clot   | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Liver disease  | <input type="checkbox"/> Thyroid disease      |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Ulcers               |

**Other Medical Problems:** Please list

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**Prior surgeries/procedures:** Please list

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**Current Medications:** Please list

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**Current Nutritional Supplements:** Please list

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**Allergies:** \_\_\_\_\_

## Family History:

Do/did you have any close family members with one of the following conditions? If yes, who?

Back or neck problems? \_\_\_\_\_

Multiple sclerosis? \_\_\_\_\_

Cancer? \_\_\_\_\_

Rheumatoid arthritis? \_\_\_\_\_

Heart disease? \_\_\_\_\_

Stroke? \_\_\_\_\_

Are there any diseases that seem to run in your family? \_\_\_\_\_

## Social History:

Tobacco Use:  Never  Former Smoker  Current Smoker  Trying to quit  Current chewer

Alcohol Use:  Never  Rare  Weekly  Daily  Heavy use

Have you ever had problematic use of alcohol or prescription or recreational drugs?  Yes  No

Work status:  Employed  Student  Retired  Homemaker  Unemployed  Disabled

Occupation: \_\_\_\_\_

Exercise regimen: \_\_\_\_\_

Do you have children?  Yes  No

# Mount Vernon Rehabilitation Medicine Associates

## *Review of systems*

**Please check any/all symptoms you have experienced in the past week**

**General:**  Fever  Sweats  Low energy  Poor appetite  Trouble sleeping  Weight change

**Eyes:**  Blurry vision  Double vision  Irritation

**ENT:**  Poor hearing  Ringing in the ears  Sinus problems  Difficulty swallowing

**Cardiovascular:**  Chest pain  Dizziness  Palpitations  Poor circulation

**Pulmonary:**  Shortness of breath  Wheezing  Cough

**Gastrointestinal:**  Abdominal pain  Nausea  Vomiting  Diarrhea  Constipation

**Genitourinary:**  Frequent urination  Burning with urination  Urinary retention  Incontinence

**Hematologic:**  Easy bleeding  Easy bruising  Paler than usual skin

**Musculoskeletal:**  Joint pain  Muscle pain  Joint swelling  Stiffness  Difficulty walking

**Neurologic:**  Weakness  Numbness  Tingling  Slurred speech  Poor balance  Tremor

**Mood:**  Anxiety  Depression

**Is there anything you would like us to know?**

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**Do you have a specific goal for this visit?**

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# MOUNT VERNON REHABILITATION MEDICINE ASSOCIATES

**Patient:** \_\_\_\_\_

**Check One: Ethnicity**

- Hispanic or Latino \_\_\_\_
- Not Hispanic or Latino \_\_\_\_
- Declined to specify \_\_\_\_

**Check One: Race**

- American Indian or Alaska Native \_\_\_\_
- Asian \_\_\_\_
- Black or African American \_\_\_\_
- Native Hawaiian or Other Pacific Islander \_\_\_\_
- White \_\_\_\_
- Decline to Specify

**Check One: Preferred Language**

- English \_\_\_\_
- Spanish \_\_\_\_
- Other \_\_\_\_ Please specify \_\_\_\_\_

**Check One: Smoking Status:**

- Never smoked \_\_\_\_
- Former smoker \_\_\_\_
- Current everyday smoker \_\_\_\_
- Heavy tobacco smoker \_\_\_\_
- Unknown if ever smoked \_\_\_\_
- Smoker, current status unknown
- Current some day smoker
- Light tobacco smoker

**Current Height** \_\_\_\_\_

**Current Weight** \_\_\_\_\_

**Email Address Required:**

\_\_\_\_\_ (This will be used to communicate upcoming appointments reminders and/or account balances only)

**MOUNT VERNON REHABILITATION MEDICINE ASSOCIATES**

**Receipt of Notice of Privacy Practices and HIPAA  
Written Acknowledgement Form**

I, \_\_\_\_\_ have received a  
copy of Mount Vernon Rehabilitation Medicine Associate notice of  
privacy practices and HIPAA.

\_\_\_\_\_  
Signature of Patient/Representative

\_\_\_\_\_  
Date

# NOTICE OF PRIVACY PRACTICES AND HIPAA

## MOUNT VERNON REHABILITATION MEDICINE ASSOCIATES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

### PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used and disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. We are committed to the privacy of your personal identifiable health information (PHI) and will use strict privacy standards to protect it from unauthorized use or disclosure.

**Understanding Your Health Record:** Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis and treatment plan. This information is referred to as a health or medical record. Understanding what is in your record and how your health information is used helps you to ensure its accuracy and make more informed decisions when authorizing disclosure to others.

**Uses and Disclosures That are permitted without your consent or authorization:** We may share your PHI, as allowed by federal law, for health oversight activities. When consistent with Virginia Law, if we believe in good faith that the use of the PHI is necessary, we will release your PHI to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

Your PHI can be shared for judicial or administrative proceedings, with public authorities for law enforcement reasons, for activities deemed necessary by appropriate military command authorities, and to coroners, funeral directors or medical examiners (about decedents). We can also release your PHI in compliance with worker's compensation or similar programs established by law.

We may release your PHI to secure payment for health care services provided by our practice such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Your PHI may also be used or disclosed for health care operations which include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. This information will then be used to continually improve the quality and effectiveness of the health care and services we provide.

We may use and disclose your PHI for treatment to provide, coordinate or manage your health care and related services with other health care providers.

We may use your PHI to contact you with appointment reminders or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. (please inform us if you do not wish to be contacted for appointment reminders).

**Required Uses and Disclosure:** We are required to disclose your PHI, upon request, to the Secretary of the United States Department of Health and Human Services in connection with the investigation of our compliance with federal privacy regulations.

**Right to Inspect and Copy Medical Information:** Your health record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to inspect and copy your PHI subject to certain limitation. We may exclude information compiled in anticipation of legal proceedings. Virginia law prohibits you from inspecting and obtaining copies of your medical records if your attending physician or clinical psychologist has filed a written statement that your review of these records would be injurious to your health. Our practice charges a fee to cover the cost of copying your PHI.



**Right to Request Restrictions on Use and Disclosure:** any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent of the actions we may already have taken relying on your authorization. You may request us to limit our communication with you to a certain way or location, for example, to call you only at work or by mail.

If you are present and give us verbal permission, we may share your PHI with a family member, friend or another person of your choosing. If you are not present or are incapacitated and it is an emergency, we may share your PHI with a family member or a friend if sharing your PHI is in your best interest.

**Right to Amend PHI:** You have the right to request us, in writing, to amend your PHI if you believe the information is inaccurate or incomplete, but you cannot have any information deleted from you PHI. We may deny your request for amendment if it is determined that the information at issue is accurate and complete or if it was not created by our practice.

**Maintenance and Destruction of Records:** We will maintain your records for a minimum of six(6) years following your last date of service. Records eligible for destruction will be disposed of in a manner that fully protects patient confidentiality. There will be no further notice given prior to the destruction of records.

**Information Protection:** We keep you oral, written and electronic PHI safe using physical, electronic and procedural means,. These safeguards follow federal and state laws. We require our employees to protect PHI through written policies and procedures. PHI is limited to only those employees who need the data to do their job.

We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We are required to follow the privacy notice that is currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions. Effective for all PHI that we maintain. We will post any revisions to our notice and you may request a copy of the revised Notice of Privacy Practices from this office.

If you feel your privacy protections have been violated, you have the right to file a written complaint with our office or with the Department of Health and Human Services. We will not penalize or discriminate against you in any manner if you choose to file a complaint.

**For more information or to file a complaint, please contact:**

**Privacy Officer  
2501 Parkers Lane  
Alexandria, VA 22306**

**-or-**

**The U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Ave, SW  
Washington, DC 20201**