Thank you for scheduling an appointment with Virginia Sportsmedicine Institute, the physical therapy division of Nirschl Orthopaedic Center.

This e-mail contains important instructions. Please read the e-mail in its entirety before proceeding with the registration forms.

ALL registration documents **MUST** be completed prior to seeing the physical and/or occupational therapist you are scheduled with no later than the business day before your scheduled appointment. Failure to do so may result in the appointment being cancelled.

You **DO NOT** need to print these forms. Once you have completed the forms, you will be prompted to electronically sign them. Once the forms have been successfully submitted, you will receive a confirmation email.

The day of your visit:
Please bring your picture ID, insurance card, and physical therapy and/or occupational therapy order. You **MUST** arrive 15 minutes prior to your appointment, or your appointment will be rescheduled. If you are going to be late, please call the office at (703) 525-5542. **If you are more than 15 minutes late, your appointment will be rescheduled.**

OFFICE ADDRESS:
1715 North George Mason Drive, Suite 503, Arlington, VA 22205
(Medical Office Building "D" located on the Virginia Hospital Center Campus)
We are located on the 5th Floor.

PARKING:
Parking Garage "C". There is a flat rate fee of **$7.00** for parking.
You can purchase discounted validations at the Cashier's Office. They ONLY come in a pack of 5 for $30.00 ($6.00 each).

Important COVID-19 office policies for visiting our office:
1. Masks are optional and available upon request.
2. Please reschedule your appointment if you are experiencing any COVID symptoms such as: coughing, fever (100.4 or higher), loss of smell/taste, chills, or other flu like symptoms.

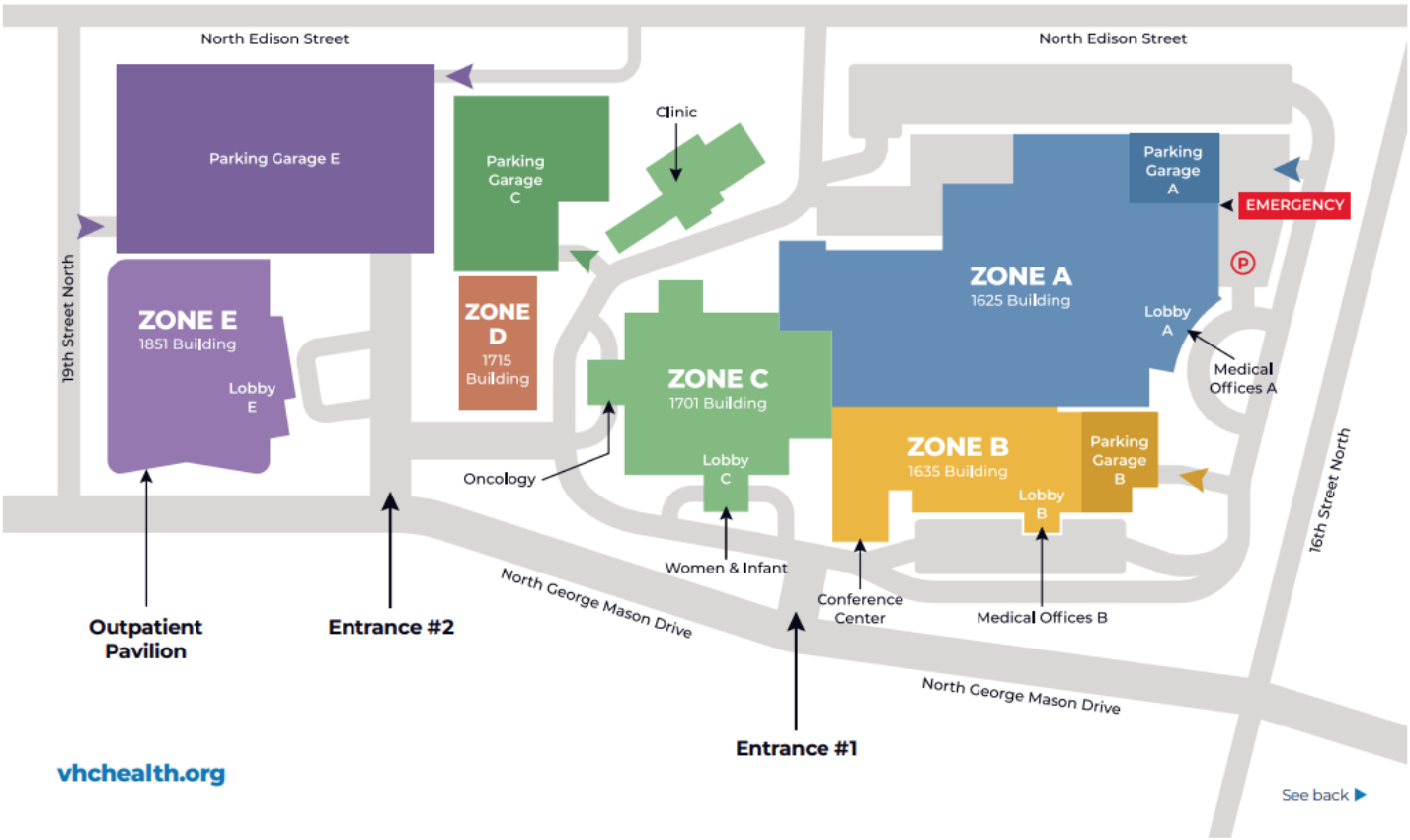
These precautions are being implemented for both the safety and well-being of all the Virginia Sportsmedicine Institute patients and Team Members. Please call if you have any questions regarding any of the information above. Again, thank you for choosing Nirschl Orthopaedic Center, and we look forward to seeing you!

Virginia Sportsmedicine Institute

Campus Directory

VHC Health Main Campus

VHC HEALTH™



Patient Registration

Patient Name: _____
Last **First** **Middle**

Date of Birth: _____ Sex: ☐Male ☐Female ☐Other: _____

Cellphone: _____ Home: _____ Work: _____

Address: _____ Zip Code: _____

Email: _____

Primary Insurance

Ins Company: _____ Address: _____

Member ID: _____Group/Enrollment #: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance

Insurance Company: _____ Address: _____

Member ID: _____Group/Enrollment #: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Emergency Contact

Name: _____ Relationship: _____Phone#: _____

I acknowledge that I was made aware of Virginia Sportsmedicine Institute, a division of Nirschl Orthopaedic Center's Privacy Policy and a copy was available for my review online and in the office.

I authorize the following person(s) to have access to my protected health information (PHI):

Name:	Relationship to patient:
_____	_____
_____	_____

I HEREBY AUTHORIZE NIRSCHL ORTHOPAEDIC CENTER/VIRGINIA SPORTSMEDICINE INSTITUTE TO SUBMIT FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I REQUEST PAYMENT FROM INSURANCE COMPANIES TO BE MADE DIRECTLY TO THE NIRSCHL ORTHOPAEDIC CENTER. PAYMENT OF SERVICES: I REALIZE THIS MAY NOT REPRESENT THE FULL PAYMENT FOR SERVICES RENDERED AND I WILL BE RESPONSIBLE FOR BALANCE DUE. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I FURTHER ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCES, DEDUCTIBLES, CO-PAYS, AND MISSED APPOINTMENT FEES NOT COVERED BY MY INSURANCE PLAN. ANY ACCOUNTS NOT PAID IN A TIMELY FASHION WILL BE REFERRED TO AN OUTSIDE COLLECTION AGENCY. I UNDERSTAND I WILL BE RESPONSIBLE TO PAY COLLECTION AGENCY FEES AND/OR ATTORNEY FEES IN THE AMOUNT OF 33% OF THE OUTSTANDING BALANCE AS WELL AS ANY COURT COSTS ASSOCIATED WITH THE COLLECTION PROCESS.
I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL ASSIGNMENT. THIS AUTHORIZATION IS IN EFFECT FOR ALL FUTURE CLAIMS UNTIL I GIVE WRITTEN NOTICE TO REVOKE IT.

Patient Signature (Parent/Legal Guardian if patient is a minor): _____ **Date:** _____

Patient Health History

Patient's Last Name: _____ **First:** _____ **MI:** _____
Date of Birth: _____ **Height:** _____**Weight:** _____ **Sex:** ☐ Male ☐ Female ☐ Other
Pronouns: _____
Current or recent occupation: _____
Home Environment:
☐Alone ☐With Spouse/Significant Other ☐With Family ☐With Roommates ☐Independent Living Center or Community
How did you hear about us? PCP/Friend/Internet? _____
Activities/Goals/Hobbies: _____

CHIEF COMPLAINT		
What area(s) of the body are you currently seeking treatment for?		
What area is most problematic at this time?		
Have you been treated for this same area or problem before?	☐ Yes	☐ No
Have you had any injections?	☐ Cortisone ☐ Epidural ☐ Other: _____	☐ Not Applicable
Do you exercise regularly or play sports?	☐ Yes	☐ No
During the past year, have you been treated by any of the following?	☐ Chiropractor ☐ Neurologist ☐ Psychiatrist ☐ Psychologist ☐ Osteopath	

Please list all relevant surgeries you have had in the past or provide a separate list:

Surgery or Procedure	Specific Body Part	Date

Please list any/all Medications you are currently taking along with the reason you take them or provide a separate list:

Patient Health History Continued

Patient Name: _____
Last **First** **Middle**

Date of Birth: _____ Sex: ☐Male ☐Female ☐Other: _____ Date: _____

Do you currently have or have you had a history of any of the following:		
☐ Heart Disease	☐ Asthma	☐ Epilepsy
☐ High Blood Pressure	☐ Congestive Heart Failure	☐ Seizures
☐ Diabetes ☐Type 1 ☐Type 2	☐ Multiple Sclerosis	☐ Thyroid Condition
☐ Poor Circulation	☐ Fibromyalgia	☐ Neurological Condition
☐ Rheumatoid Arthritis	☐ Migraines	☐ Eating Disorder
☐ Osteoarthritis	☐ Headaches	☐ Vestibular Disorder
☐ HIV/AIDS	☐ High Cholesterol	☐ Fainting Spells
☐ Liver Disease	☐ Depression	☐ Osteoporosis
☐ Stroke	☐ Anemia	☐ Chronic Infections
☐ Blood Clots / DVT	☐ Lupus	☐ Other:_____
☐ Cancer ☐Type: _____ _____	☐ Hepatitis ☐ A ☐ B ☐ C	Alcohol – A drink is 1 shot of liquor, or 1 glass of wine, or 1 bottle/can of beer ☐ Abstainer (less than 12 drinks/ year) ☐ Light (1-13 drinks/month) ☐ Moderate (4-14 drinks/week) ☐ Heavy (>2 drinks/day)
Do you smoke, vape, or use tobacco? ☐ Yes ☐ No	Do you have a heart condition or problem? ☐ No ☐ Yes, please describe: _____ _____ _____	***Women Only:*** Are you pregnant or planning on becoming pregnant? ☐ Yes ☐ No
Do you have an implanted medical device? (Pacemaker, artificial joint, cosmetic implant, etc.) _____ _____ _____ _____	Do you have or are you experiencing any of the following? Please check all that apply. ☐ Fatigue ☐ Weakness ☐ Internal Defibrillator ☐ Chest Pain ☐ Insulin Pump ☐ Dizziness ☐ Numbness/Tingling ☐ Nausea/Vomiting ☐ Fever/Chills/Sweats ☐ Loss of Bowel Function ☐ Loss of Bladder Function	Do you have any allergies? Please check all that apply or provide the information. ☐ Adhesives ☐Shellfish ☐ Latex ☐ Iodine ☐ Lidocaine ☐ Medications/Drugs: _____ _____ _____ ☐Other: _____ _____

Notice of Disclosure of Ownership Interest

Virginia Sportsmedicine Institute (VSI) is wholly owned by Nirschl Orthopaedic Center; however, you may seek physical therapy treatment at outside facilities.

By my signature below, I am acknowledging this Notice of Disclosure of Ownership Interest.

_____ _____

Patient Signature (Parent/Legal Guardian if patient is a minor) **Date**

_____ **DOB:** _____

Patient Name Printed

Financial Policy Statement

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. The office will file verified insurance for payment of bills as a courtesy to the patient, but not all services are covered by all insurance companies. *It should be understood that by accepting the services, the patient is responsible for payment.* We do not submit to third-party payors.

Co-payments and deductibles must be paid upon the patient's arrival. If you have an outstanding balance, we appreciate prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan with our billing department. Additionally, it is your responsibility to provide any necessary referral information to us that your insurance company requires prior to your visit. It is extremely important that you notify us of any changes to your insurance information prior to each visit. Failure to do so can lead to unpaid/denied claims that the patient will be responsible for.

Our staff may assist you with insurance questions; however, it is your responsibility as the patient to know and understand your medical benefits.

There may be occasions when your course of treatment requires the use of an orthopedic appliance or brace to facilitate your rehabilitation. Some insurance companies do not cover durable medical equipment. If you have any questions regarding this appliance or brace, do not leave the office with it in your possession. Due to health regulations braces, shoe inserts, gloves, putty, or any other such item cannot be returned.

If you fail to provide us with a 24-hour notice of cancellation or no-show to your scheduled appointment, we reserve the right to charge you a $50 no show fee.

The administrative staff and management welcome the opportunity to discuss any aspect of our financial policy. We appreciate your confidence and strive to provide quality healthcare.

_____ _____

Patient Signature (Parent/Legal Guardian if patient is a minor) **Date**

_____ **DOB:** _____

Patient Name Printed