



## **What to Expect at The Jackson Clinics** *Hands on Physical Therapy*

**We work as a team.** You will be evaluated by your physical therapist (PT) and each visit you will be seen for up to 30 minutes by that therapist. You will also be seen by a licensed physical therapist assistant (PTA), primarily for exercises prescribed by your therapist. Your total treatment time is about 60 minutes, sometimes longer or shorter based on your needs. Remember, we work as a team; therapist, assistant, ***and*** you, the patient. Your therapist is responsible for determining those needs based on your evaluation.

**The Plan of Care.** Your physical therapist will determine your plan of care based on your diagnosis, your comprehensive evaluation that the therapist performs, and the recommendation of your physician. Essentially, PT's do four things;

1. *Stretch*
2. *Strengthen*
3. *Functionally retrain, and*
4. *Educate the patient* about their condition and what they need to do at home to overcome the problem.

**You can expect a global evaluation.** We look at you as a machine. In therapy we like to say that “we fix the world’s most complex machine.” During your exam your therapist looks for dysfunction in your machine that may contribute to your painful condition, then develops a plan to make the machine function normally again. If your therapist or assistant is out of the clinic for any reason, such as illness, continuing education, or vacation, we will make every effort to have a replacement so that your **plan of care** is not interrupted. We understand that patients can get a little attached to their therapist, but be assured, if your therapist is out, the person treating you is licensed, qualified, and is aware of your needs based on your chart and consultation with your therapist.

**Exercise.** Exercise is the core of all of our interventions. Your therapist determines from your exam and history what exercises are appropriate, but we need your help. Home exercise is a cornerstone of our treatment. We will give you plenty to do at home, and to recover you need to be compliant. Again, if your therapist is away it is essential that you continue coming to therapy for no other reason than to avoid an interruption in your exercise program.

## PATIENT GUIDELINES

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*Welcome and thank you for selecting **The Jackson Clinics** for your physical therapy care.*

*Our mission is to offer you the highest quality care in a comfortable, efficient and safe manner. Listed below are some guidelines for your review. Throughout the time you receive services from our organization, please feel free to contact any member of our team with questions or if you need any information.*

*Wishing you good health,  
The Jackson Clinics*

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- **Primary Care Referrals:** Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.
- **Co-Payments:** Co-payments must be paid upon the patient's arrival. We accept cash, check and most major credit/debit cards.
- **Non-covered services:** Supplies and equipment must be paid for at the time of service.
- **Attire for Physical Therapy:** Shorts or sweatpants with an elastic waistband may be ideal, particularly if we are treating the lower extremities. Loose-fitting clothing is recommended for treatment of the upper extremities.
- **Tardiness:** Please call if you are running late. Physical therapy treatments may be abbreviated for patients arriving 10-15 minutes late. If you arrive more than 15 minutes late you may be asked to reschedule. Obviously, we try to deliver the same respect for your time – if we are running late, the session will be completed in its entirety.
- **Appointment/Cancellation Policy:** I understand that physical therapy has been prescribed for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I understand that if I am late for my appointment, I may be given the opportunity to reschedule my appointment or to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three cumulative appointments, The Jackson Clinics may discharge me from care for being non compliant.

I understand and agree that The Jackson Clinics requires a 24 business hours notice of cancellation. Should I fail to give 24 hours notice of cancellation or fail to show up for an appointment, I will be charged a \$30 cancellation/no show fee (which is not covered by insurance).

I have read and understand the above guidelines.

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Signature of Patient or Responsible Party

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Date



# HEALTH CARE - REGISTRATION FORM

(Please Print & Complete All Sections)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Auto Accident?  Yes  No PCP \_\_\_\_\_

## PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Marital Status (Circle One)	
						Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address		City	State	ZIP Code	Social Security		Home Phone No. ( )
Date of onset/problem / /	Occupation	Employer		Employer Phone No. ( )			
Chose Clinic Because/Referred to Clinic By (Please Check one Box) <input type="checkbox"/> Dr _____ <input type="checkbox"/> Ins Plan							
<input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____							

May we contact you regarding your schedule via email?  Yes  No *if yes*, email address: \_\_\_\_\_

Other Family Members Seen Here \_\_\_\_\_

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Primary Insurance					
Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$		
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____							
Name of Secondary Insurance (if applicable)		Subscriber's Name		Group #	Policy #		
Person Responsible for Bill	Birth Date / /	Address (if different)				Home Phone No. ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation	Employer	Employer Address			Employer Phone No. ( )		
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____							
Do you have an attorney for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Attorney's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone No. ( )

## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to *The Jackson Clinics, LLC*. I understand that I am financially responsible for any balance. I also authorize *The Jackson Clinics, LLC* or insurance company to release any information required to process my claims.

x \_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

# PATIENT HISTORY FORM

Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please complete all required information. Use reverse side, if needed, for additional space

1. Have you ever had?

High Blood Pressure	No <input type="checkbox"/> Yes <input type="checkbox"/>	Breathing Problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Heart Trouble	No <input type="checkbox"/> Yes <input type="checkbox"/>	Fracture	No <input type="checkbox"/> Yes <input type="checkbox"/>
Circulation Problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Stroke	No <input type="checkbox"/> Yes <input type="checkbox"/>
Seizures	No <input type="checkbox"/> Yes <input type="checkbox"/>	Arthritis	No <input type="checkbox"/> Yes <input type="checkbox"/>
Dizzy Spells	No <input type="checkbox"/> Yes <input type="checkbox"/>	Acrophobia	No <input type="checkbox"/> Yes <input type="checkbox"/>
Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/>	Claustrophobia	No <input type="checkbox"/> Yes <input type="checkbox"/>
Other Illness	No <input type="checkbox"/> Yes <input type="checkbox"/>		

2. Have you ever had Surgery? No  Yes  If yes, give Date(s), Operation(s), and Outcome(s)

\_\_\_\_\_

3. Do you have any metal anywhere in your body (other than your teeth)? No  Yes

4. Do you have a Cardiac (heart) Pacemaker? No  Yes

5. (For Women Only) Are you now pregnant? No  Yes  Date of last period \_\_\_\_\_

6. List medical tests done for this condition \_\_\_\_\_

\_\_\_\_\_

7. List any Allergies you have \_\_\_\_\_

8. List any Medications you are now taking \_\_\_\_\_

\_\_\_\_\_

9. Have you ever had Physical Therapy treatments before? No  Yes

If Yes, indicate Where, When, and for What problem \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. Describe briefly the history of your present accident or illness \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Please list any past or present medical conditions you have \_\_\_\_\_

\_\_\_\_\_

12. Please list prior accidents or work injuries \_\_\_\_\_

\_\_\_\_\_

13. Work Status  Regular Duty  Light Duty  Off Duty

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

*If not Patient, indicate relationship ( Parent, Guardian, Other )*

# SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

**THE JACKSON CLINICS, LLC**

**EFFECTIVE DATE APRIL 4, 2005**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

Please review the full Notice of Privacy Practices (NPP). If you have any questions about this notice, please contact Anna Jackson our Privacy Official at (540)687-8181.

## **WHO WILL FOLLOW THIS NOTICE:**

This notice describes our privacy practices. We are affiliated with and in some circumstances may operate under the policies and practices of:

<ul style="list-style-type: none"><li>• The Jackson Clinics, LLC - Centreville</li><li>• The Jackson Clinics, LLC - Fairfax</li><li>• The Jackson Clinics, LLC - Franconia</li><li>• The Jackson Clinics, LLC - Herndon</li><li>• The Jackson Clinics, LLC - Lorton</li><li>• The Jackson Clinics, LLC - Manassas</li></ul>	<ul style="list-style-type: none"><li>• The Jackson Clinics, LLC - Oakton</li><li>• The Jackson Clinics, LLC - Old Town/Alexandria</li><li>• The Jackson Clinics, LLC - Shirlington/Arlington</li><li>• The Jackson Clinics, LLC - Skyline/Falls Church</li><li>• The Jackson Clinics, LLC - Tyson</li><li>• The Jackson Clinics, LLC - Worldgate/Herndon</li></ul>
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All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

## **OUR PLEDGE REGARDING HEALTH INFORMATION:**

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

## **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Appointment Reminders**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

## **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.**

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to and Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Anna Jackson, Privacy Official at (540)687-8181.

## **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Anna Privacy Official. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

## **OTHER USES OF HEALTH INFORMATION**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



## Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, have received the Notice of Privacy Practices from The Jackson Clinics.

X \_\_\_\_\_ Date \_\_\_\_\_  
*Signature*

In lieu of patient signature, I, \_\_\_\_\_, a staff member of The Jackson Clinics state that \_\_\_\_\_ has been given our current Notice of Privacy Practices.

X \_\_\_\_\_ Date \_\_\_\_\_  
*Signature*

### Discussion of Treatment/Medical Information

A. If you are accompanied to your physical therapy session(s) is it acceptable to discuss your medical information with the individual(s) present? Yes \_\_\_\_\_ No \_\_\_\_\_

B. Is there any individual, besides your doctor and involved health care practitioner(s), with whom The Jackson Clinics has permission to discuss your treatment plan/medical information? Please check as appropriate and print the individual's name:

Spouse/Significant Other	Y _____ N _____	_____
Son/Daughter	Y _____ N _____	_____
Son-in-law/Daughter-in-law	Y _____ N _____	_____
Friend	Y _____ N _____	_____
Other	Y _____ N _____	_____

C. The Jackson Clinics is actively involved in the clinical education of physical therapy students from accredited programs at respected Universities.

I grant students permission to be involved in my care in ways which may involve review of personal health information, including the discussion and observation of my treating physical therapist?

Y \_\_\_\_\_ N \_\_\_\_\_

I permit students to execute care procedures as directed/supervised by the primary physical therapist?

Y \_\_\_\_\_ N \_\_\_\_\_

### Place of Treatment

To facilitate your care, a portion of your treatment may take place in the open gym area of our clinic. Do you agree to this? Y \_\_\_\_\_ N \_\_\_\_\_



## FINANCIAL POLICY STATEMENT

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We would like to thank you for choosing The Jackson Clinics, LLC and allowing us to provide your healthcare needs. The policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients at the least cost.

Care delivered by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or gender.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding financial responsibility and our payment policy.

### RESPONSIBILITY FOR THE BILL

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the clinic in effect at the present time.

### POINT OF SERVICE COLLECTIONS

Payment for service is due at the time to service(s) is rendered and non-emergency services may be declined until the necessary payment arrangements have been accomplished.

Payment will be accepted in cash, checks, and most major credit/debit cards. We will be happy to file verified insurance on your behalf. For your convenience if your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of \$50.00.

Patients unable to comply with the Point-of-Service payment policy will be referred to the administrative office for necessary arrangements.

### PAYMENT ARRANGEMENTS

The clinic will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangement for payments will be made at the clinic's discretion, based on the amount of the patient's liability and the patient's ability to pay based on a completed credit application.

### PATIENT SCHEDULING

Every effort will be made to schedule the patient at the patient's convenience. Patients will be advised of the clinic payment policy at the time appointments are made along with the best estimate of the cost of the office visit.

### ACCEPTANCE OF INSURANCE

The clinic will accept "Assignment of Benefits" on verified insurance policies and submit a bill to the carrier on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Claims filed will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all the claims not paid within the allowed period of time.

### VERIFICATION OF INSURANCE

Because of the wide range of insurance plans in effect, the clinic will verify insurance coverage, deductibles and other limits, prior to acceptance for payment of services.

### PRE-CERTIFICATION

The clinic will make every effort to pre-certify all services, provided the clinic is supplied with the necessary information.

REJECTED CLAIMS

Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf.

RELEASE OF INFORMATION

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

PATIENT RESPONSIBILITY

Balances after insurance are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the clinic.

Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers the service or not.

The clinic cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

OUTSTANDING BILLS

The clinic reserves the right to request deposits and payments for outstanding balances. Deposits will be based on the outstanding balance plus the patient’s share of the bill for the new services to be performed.

HEALTHCARE LIENS

The clinic reserves the right to file healthcare liens against the patient and other responsible parties as is deemed appropriate to protect the clinic interest.

BAD DEBTS/LEGAL ACTION

If the account is not paid in full or satisfactory arrangements made within the allowable time frame, the clinic reserves the right to refer the account to an attorney and/or a collection agency for collection of the balance.

I agree to assume responsibility for all charges incurred should collections of this balance become necessary including court costs and attorney’s fee.

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

In the event that The Jackson Clinics must file a law suit to collect a debt, I agree the jurisdiction shall be in the courts of Loudoun County, VA.

I have read the Financial Policy/Policy Statement and understand regarding above.

\_\_\_\_\_  
Patient/Guarantor Signature                      Print Name                      Date

\_\_\_\_\_  
Witness-Staff Employee Signature                      Print Name                      Date