PATIENT PRE-SCREENING QUESTIONNAIRE

Due to the ongoing COVID-2019 Pandemic, all caregivers/patients are required to complete this form prior to being seen at ARSO Neuro Rehab and Orthopedic Center. Your visit is subject to approval upon completion of this form. Effective immediately, only 1 adult is to accompany our patient visits, accompanying children who are not being seen as patients are also restricted. These rules are being enforced to keep our patients and staff as well as the rest of your loved ones safe and healthy.

	YES	NO
Have you been diagnosed with COVID-19 **IF YES WHEN:**		
Has the patient, caregiver or anyone in your household have travelled **outside the US in the past 2 weeks (14 days)** **IF YES, WHERE _____**		
Has the patient, caregiver or anyone in your household have travelled **outside of Maryland in the past 2 weeks (14 days)** **IF YES, WHERE _____**		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **suspected to have contracted coronavirus (COVID-19)**? Including being ***tested*** for COVID-19, & being in ***self isolation*** for COVID-19		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **confirmed to have contracted coronavirus (COVID-19)**?		
Has the patient or caregiver currently been exposed to someone **with flu-like symptoms (cough, shortness of breath or fever)**		
PLEASE CIRCLE IF SYMPTOMS ARE CURRENTLY BEING EXPERIENCED BY CAREGIVER, PATIENT OR BOTH		
IN THE LAST 72 HOURS HAS THE PATIENT OR CAREGIVER EXPERIENCED		
FEVER greater the 100.4 F (38.0 C)		
COUGHING		
SORETHROAT / LOSS OF SMELL OR TASTE		
DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING		
MUSCLE ACHES		
STOMACH PAINS		
VOMITING OR DIARRHEA		
PINK EYE/ RED EYES		
RASH		
FATIGUE OR FEELING UNWELL		

*****Please return this form to the front desk when completed*****

By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice and may be subject to applicable laws during this pandemic.

Patient/Caregiver:_____ **Date:_____**

Caregiver temp:_____ **Patient temp:_____**

ARSO
Neuro Rehab and Orthopedic Center
"Recovery Thru Excellence"

(Please read thoroughly)

ARSO Neuro Rehab and Orthopedic Center strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last-minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- If you are **15 minutes late** for your appointment and fail to notify us, treatment may be cancelled, and a fee charged for missing the appointment.
- A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE**, or a fee will be charged for that appointment.
- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows or cancellation will result in the cancellation of all remaining scheduled appointments.
- At week's end, ALL PATIENTS, regardless of insurance/third party payor, will be charged a **$75.00** CANCELLATION FEE for each late, late cancelled, or no-show appointment. **THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.**
- A Re-Schedule fee of **$25.00** will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

All of the staff at ***ARSO Neuro Rehab and Orthopedic Center*** appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

We look forward to working with you to meet your physical therapy goals.

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

_____ ____ /____/ _____

Patient Acknowledgement/Signature Date

ARSO
Neuro Rehab and Orthopedic Center
"Recovery Thru Excellence"

DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility or the Central Billing Office to inquire about your personal health information or billing information. Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues. Please take a few moments to complete this form.

I authorize ARSO Neuro Rehab and Orthopedic Center, LLC to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name	Relationship	Phone Number

I wish to be contacted in the following manner:
ϒ Home_____
ϒ Work_____
ϒ Cell _____
ϒ Written Communication
ϒ E-Mail/Other_____

I grant ARSO permission to leave a message on my voicemail regarding appointments/information with detailed information: ϒ YES ϒ NO

ϒ To send mail to my home/work address
_____
ϒ To send fax to this number_____

_____ _____
Signature of Patient/Legal Representative Date

_____
Print Name of Patient or Legal Representative

ARSO
Neuro Rehab and Orthopedic Center
"Recovery Thru Excellence"

Patient Authorization Record

Initial here	
	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by *State of Maryland* Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that ARSO Neuro Rehab and Orthopedic Center, LLC may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to ARSO Neuro Rehab and Orthopedic Center, LLC for services rendered. ➢ I agree that ARSO Neuro Rehab and Orthopedic Center, LLC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to ARSO neuro Rehab and Orthopedic Center, LLC for services rendered.
	Patient Agreement ➢ I agree to pay to ARSO Neuro Rehab and Orthopedic Center, LLC charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay ARSO Neuro Rehab and Orthopedic Center, LLC collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to *ARSO Neuro Rehab and Orthopedic Center, LLC* in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that *ARSO Neuro Rehab and Orthopedic Center, LLC* may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to *ARSO Neuro Rehab and Orthopedic Center, LLC* in applying for benefits under Workers Compensation is complete and accurate. I agree that *ARSO Neuro Rehab and Orthopedic Center, LLC* may give intermediary's information necessary to process claims.

Patient signature Date

Printed patient name Witness Signature Date

Signature of Legal Representative/POA

12200 Tech Rd. suite 120 Silver Spring, MD 20904
Phone: 301-588-3929 Fax: 301-588-3964
arso@arso-rehab.com

ARSO
Neuro Rehab and Orthopedic Center
"Recovery Thru Excellence"

PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Social Security# ----------_____ Appointment Date:_____/_____/_____
Patient Name: _____ Day Time Phone:(_____)-_____-_____
Address:_____ Birth Date:____/____/_____
City:_____State:_____Zip: _____ Age: _____ Sex:_____Marital Status: _____
Guarantor Name (if applicable):_____Phone:(_____)_____-_____
Email Address: _____ Work Phone:(____)-_____-_____
Primary Care Physician/ PCP: _____ PCP's Phone: (____)_____-_____
How did you hear about our facility? _____

REFERRAL INFORMATION

Name of physician who referred you to physical therapy: _____
Referring physician's Phone: (_____) -_____-_____ Fax: (_____)-_____-_____
Accident/Injury/Onset Date:_____/_____/_____ Reconstructive Surgery: Y____N_____
Emergency Contact: _____ Contact Phone: (_____)-_____-_____
Relationship: _____

AUTO ACCIDENT

Is this an Auto Accident claim? Y____N_____
Accident/Injury Date: _____
What is YOUR primary auto insurance company's name? _____
Your auto claim number: _____
Claim adjuster's name: _____
Claim adjuster's phone and fax: _____
Has your adjuster approved physical therapy visits?_____Keep in mind that ARSO Neuro Rehab and Orthopedic Center MUST have proper verification from the adjuster that this claim is approved BEFORE you can be scheduled for an appointment.
Have you submitted your PIP application? Y____N_____

WORKERS' COMPENSATION

3VI) Is this a W/C claim? Y_____N_____
3vii) W/C claim number: _____
3viii) W/C Case Adjuster Name: _____
3ix) W/C case adjuster Phone: (____) -_____-_____Fax: (_____) -_____- _____

ARSO
Neuro Rehab and Orthopedic Center
"Recovery Thru Excellence"

LITIGATION CASES

Is there an attorney assigned to this case: Y___ N___?
If yes, please print the name of the law firm / attorney: _____
Attorney Phone: (_____)-_____-_____Fax:(_____)-_____-_____
Have you signed ARSO's Attorney Authorization (AA) form attached? Y____N_____

HEALTH INSURANCE

PRIMARY INSURANCE

Primary Health Insurance: _____
Policy #:_____Group#:_____Insured Name: _____
Subscriber Name:_____Subscriber DOB: _____
Insurance Phone: (_____)-_____-_____ext.:_____Fax (_____)-_____-_____

SECONDARY INSURANCE

Secondary Health Insurance: _____
Policy #:_____Group#:_____Insured Name: _____
Subscriber Name:_____Subscriber DOB: _____
Insurance Phone: (_____)-_____-_____ext.:_____Fax (_____)-_____-_____

MEDICAL HISTORY

Please describe reason for which you are seeking therapy, including when and how the problem first occurred:

_____
_____

Have you ever had these symptoms before? Yes___No_____
Have you been hospitalized because of this condition? Yes___(Admission date_____Discharge date_____)
No____
Are you presently taking medication (including prescription, over the counter and herbal)? Yes____No_____

Medication	Dosage	Prescribing Physician

Please list any foods, medications, etc. that you are allergic/sensitive to: * If needed continue on back of page

_____
_____
_____

Do you now or have you in the past smoked? Yes___No_____
If yes, for how long?_____How much? _____

ARSO
Neuro Rehab and Orthopedic Center
"Recovery Thru Excellence"

Do you now or have you in the past drank alcohol? Yes____ No_____
If yes, how much?_____How often? _____
Have you fallen in the last 6 months? Yes_____No_ If so, number of times _____
Have you tested positive for TB? Yes___No_____
If so, has it been treated and cleared? _____
Have you tested positive for any other communicable infections? (e.g. C-Diff, MRSA, shingles, VRE, ESBL, hepatitis, etc.) If so, please list them:

It is very important that we have a complete medical history so that we can better serve you.
Do you have, or have you ever had any of the following?

Diabetes	Yes	No	Recent upper respiratory infection	Yes	No
Chest pain/angina	Yes	No	Poor tolerance to heat	Yes	No
High blood pressure	Yes	No	Poor tolerance to cold	Yes	No
Heart attack	Yes	No	Any accident resulting in trauma	Yes	No
Heart palpitations	Yes	No	Recent fractures	Yes	No
Pacemaker	Yes	No	Surgeries	Yes	No
Stroke	Yes	No	Metal implants	Yes	No
Brain injury	Yes	No	Dizziness/fainting	Yes	No
Neurological disease	Yes	No	Bowel/bladder abnormalities	Yes	No
Seizures	Yes	No	Are you pregnant?	Yes	No
Headaches	Yes	No	Ringing in your ears	Yes	No
Cancer	Yes	No	Nausea/vomiting	Yes	No
Osteoporosis	Yes	No	Mental health problems	Yes	No
Skin abnormalities	Yes	No	Hypoglycemia	Yes	No
Asthma/breathing difficulties	Yes	No	Acid reflux/GERD	Yes	No
Liver/gallbladder problems	Yes	No	Difficulty chewing or swallowing	Yes	No
Kidney problems	Yes	No	Special diet guidelines	Yes	No
Hernia	Yes	No	Other _____		
Rheumatoid arthritis	Yes	No	Other _____		

For all "yes" responses above please briefly explain and give the approximate dates:

_____

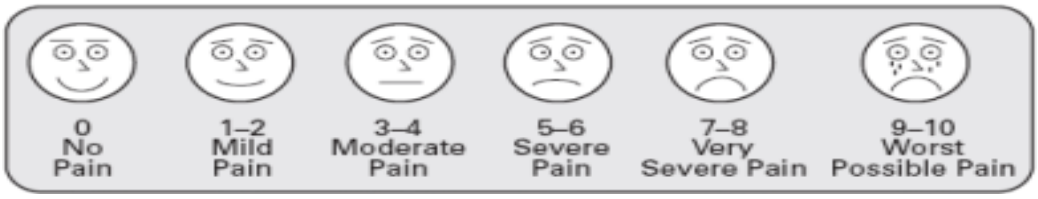
_____

12200 Tech Rd. suite 120 Silver Spring, MD 20904
Phone: 301-588-3929 Fax: 301-588-3964
arso@arso-rehab.com

ARSO
Neuro Rehab and Orthopedic Center
"Recovery Thru Excellence"

PAIN

On a scale of 1-10, using the pictures, what is your pain level? 0 1 2 3 4 5 6 7 8 9 10



WORK HISTORY

What is/was your profession?

_____

LEARNING NEEDS

Is English your primary language? Yes___No_____ If no, what is your primary language? _____

Please describe any hearing or vision limitations you may have. _____

What is your educational background? Grade school High school College Advanced degree

Please describe what you would like to learn about your therapy or condition.

_____

_____

How do you learn best? Verbal instruction Demonstration Written handouts Pictures

CULTURAL/RELIGIOUS INFORMATION (OPTIONAL)

Please describe any cultural/religious beliefs or values that we should take into consideration during your treatment:

_____

_____

What is your faith tradition/denomination? _____

Would you like a chaplain to contact you for emotional or spiritual support?

Yes (telephone number:_____) No

SOCIAL INFORMATION

What is your marital status? Single Married Significant Other Separated Divorced Widowed

Do you have any children? Yes__ No_____ If yes, how many? _____

Do you currently live with anybody? Yes___ No___ If yes, who? _____

Who is most involved in helping you recover from your condition?

_____

What community activities are you having difficulty with since your injury/illness?

_____

_____

ARSO
Neuro Rehab and Orthopedic Center
"Recovery Thru Excellence"

Do you have any difficulty with thinking skills such as memory, attention, or problem solving? Yes___No__If yes, please explain_____

_____

_____

Do you have any difficulty communicating, such as difficulty speaking, finding your words, or understanding what others say? Yes___No____ If yes, please explain:

_____

_____

_____

ADDITIONAL INFORMATION

Please provide any additional information that would be helpful for us to have.

_____

_____

_____

Patient Signature:_____Date: _____

12200 Tech Rd. suite 120 Silver Spring, MD 20904
Phone: 301-588-3929 Fax: 301-588-3964
arso@arso-rehab.com