truong REHABILITATION CENTER

Pogonia Medical Arts Building, 4604 Spotsylvania Parkway, Suite 303
Fredericksburg, VA 22408
(540)374-3164 Fax (540) 899-1342
www.truongrehab.com

Welcome_____!

Our practice combines conventional medicine with complementary approaches to look at the whole person, not just the disease. Our doctor uses state-of-the-art medical treatment approaches and equipment to tackle your illness on all fronts, helping you heal in a friendly, professional atmosphere.

Enclosed, you will find a New Patient Record packet that we would like you to complete and bring with you on the day of your visit. It is important that we have the most up-to-date information so the doctor can deliver the best quality care during your visit.

Date: _____ Time: _____

****PLEASE PLAN TO ARRIVE 20-30 MIN PRIOR TO YOUR APPT TIME FOR PROCESSING YOUR PAPERWORK. THIS ENSURES YOUR BEING SEEN IN A TIMELY MANNER.******

You will need to bring the following information to your appointment:

•Medical Records from all physicians who have seen you for the condition for which you are seeing us. THIS IS VERY IMPORTANT!
•X-ray/MRI/CT reports
•Insurance referral from your Primary Care Physician, if needed
•Insurance Card(s) and Picture I.D.
•Co-pay (Cash/Checks/Credit Cards). This is required at the time of the appointment.
•Completed New Patient Record (front and back).

We look forward to meeting you. We strive to give every patient a complete evaluation. Please help us maintain our quality service by giving us ample notice if you need to reschedule.

There will be a $50 cancellation fee charged directly to the patient when an appointment is cancelled less than 48 business hours prior to the appointment time.

Directions to our office:

From 95 North: From Route 1 South:
-Take EXIT 126, toward FREDERICKSBURG
-Turn LEFT onto US-1 N/US-17/JEFFERSON DAVIS HWY. -Turn RIGHT onto MARKET ST.
-Turn RIGHT on SPOTSYLVANIA AVE.
-Go 0.2 mi, End at 10340 Spotsylvania Ave the brick building on the right-hand side

From 95 South:
-Take EXIT 126A, toward SPOTSYLVANIA
-Turn RIGHT onto MARKET ST
-Turn RIGHT on SPOTSYLVANIA AVE.
-Go 0.2 mi, End at 10340 Spotsylvania Ave the brick building on the right-hand side

-Turn LEFT onto MARKET ST.
-Turn RIGHT on SPOTSYLVANIA AVE. -Go 0.2 mi, End at 10340 Spotsylvania the brick building on the right-hand side

From Route 1 North:
-Turn RIGHT onto MARKET ST
-Turn RIGHT on SPOTSYLVANIA AVE
-Go 0.2 mi, End at 10340 Spotsylvania Ave the brick building on the right-hand side

Thank you,

Dr. Anne Truong and Staff

Board Certified Physical Medicine and Rehabilitation

PLEASE COMPLETE FRONT AND BACK!

Patient:

First name:_____ Last Name: _____ Middle Initial: _____ Age:_____

Date of Birth: ____/____/_____ (Circle one) Male Female

Mailing Address: _____ Cellular Ph: (_____)_____-_____

Physical Address:_____ Home Ph:(_____)_____-_____

City:_____ St. _____ Zip _____ VA Driver License#: _____

Social Security #: _____-_____-_____ Email Address _____

Emergency Contact: _____ Relationship:_____ Emergency Phone:(_____)_____-_____

Pharmacy: _____ Location: _____ Phone:_____

Spouse: (must complete)

Spouse Name: _____ Date of Birth: ____/____/_____

Occupation: Spouse's Work Ph: (_____)_____-_____ Social Security #: _____-_____-_____

Spouse's Work Address_____

Employer: (must complete)

Employer: _____ Occupation: _____

Work Address:_____

Work Phone:(_____)_____-_____Ext____

Workman's Compensation (WC): (must complete)

Are you here for care and treatment related to an injury or issue at work (circle one)? YES / NO

Have you filed a workers' compensation claim (circle one)? YES / NO

If Yes to any of the above, we can't treat you unless we have a prior, written authorization from your WC carrier

W/C Carrier: Contact: _____ _____

Phone Number: Fax Number: _____ _____

Claim #: _____ Date of Injury: _____

Responsible Party (for insurance): (must complete)

Responsible Party or Guardian (if under 18): _____

Address: _____ Relationship: _____

Phone Number: (_____)_____-_____ Social Security #: _____-_____-_____

Employer: _____ Work Phone: (_____)_____-_____

Insurance: (must complete)

Primary Insurance Co: _____

ID#: _____ Plan: _____ Group: _____

Subscriber's Name: _____ Relationship: _____

Effective Date of Plan: _____

Secondary InsuranceCo: _____ ID#: _____ Plan: _____ Group: _____

Subscriber's Name: _____ Relationship: _____

*To whom do you authorize us to release information? Answering machine yes no

Work voice mail yes no Other: (Name and Relationship): _____

*Preferred method of appointment reminder: Phone Email Both

*What number do you want us to call for appointment reminders and test results?_____

REHABILITATION MEDICINE PHYSICIANS

POLICIES AND PROCEDURES

AUTHORIZATION FOR TREATMENT

I consent to examination, treatment, and procedures that may be performed during office visits as ordered by my physician, or by his/her consultants, associates, or designees; by any employee personnel; and/or agent of my physician who may carry out part or all of my treatment including emergency treatment considered necessary by my physician and/or designated providers. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made or implied regarding my care and treatment. : I hereby authorize my physician to retain, preserve, and/or use for medical documentation, scientific and/or teaching purposes any photographs, specimens and/or tissues taken as a part of my hospital procedure. I understand these will be properly discarded according to my physician's policy. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C Virus. Those test results will be shared with the healthcare worker who was exposed.

FINANCIAL RESPONSBILITY & ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to this physician for services covered by insurance. I assume financial responsibility for and agree to make payment in full to this physician for all charges for services or medical supplies furnished but not covered by my insurance carrier. Authorization for office visit, if required, must be obtained in advance from your insurance carrier. Though we can assist in this, the patient has primary responsibility for obtaining this important pre-treatment authorization. (Please be aware that a "referral" from your Primary Care Physician is not an "authorization"). Should you arrive at the office without the required insurance authorization, and still choose to be seen by the doctor, you will be expected to pay 100% of all office charges at the time of service. This policy applies to all patients, including those with HMO/PPO coverage. Should you come for a scheduled appointment without the required authorization, and subsequently elect to reschedule, a $25.00 service charge will be added to your account. Insurance does not cover this charge. Any co-pay and/or fees for noncovered services are due at time of visit. If no payment is received from your carrier within 45 days of initial filing, you may be asked to pay your balance in full. We appreciate your understanding. Please Note: Your insurance provider has a contract with you, and you are ultimately responsible for all charges. Should you receive a bill from our office, payment in full of the "Patient Balance" is due by the due date indicated, unless other arrangements have been specifically made. There will be a $10.00 charge for every subsequent statement that is sent out to you for an unpaid balance. Payment of all balances is due prior to your next appointment.

Returned Check Policy: If a check is returned for insufficient funds, $50.00 will be added to your account. If any balance is not paid in full within 48 hours, an additional $50.00 fee will be added.

Collections Policy: Accounts 120 days overdue, without an arranged payment plan, or as deemed warranted by the

practice, will be turned over to our attorney for collection. In the event that your account is referred for collection, you agree

to pay all costs incurred in collecting the amount due, including an additional amount for collection fees.

RESCHEDULING/CANCELING/NO-SHOW POLICY/STATEMENT: In order to ensure that our patients enjoy the most timely and reliable access to Monday to Friday 8:30am – 4:30pm is established a firm policy of "No Shows" and late cancellations

Should you fail, without notice, to keep a scheduled appointment, or fail to cancel an appointment with less than 48 business hours notice, this will result in a charge $50 fee on your credit card on file. We will collect your credit card information when you schedule your first appointment and keep confidentially in your account.

To cancel your appointment, you can call 540-374-3164, if the office is closed, you can leave a message on voice mail. You can also go online to Patient Portal on our website at www.truongrehab.com or use the Healow app on your smart phone. Insurance will not cover this charge. Note: A 5% fee will be assessed for refund if appointment is canceled prior to 48 business hours. A 10% fee will be assessed for paid treatment on PRP/Stem Cell/BHRT (Hormone)/Weight Loss/Sexual/Aesthetics if canceled.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize this physician to release to my insurance carrier and its designated agents any information concerning medical care, advice, treatment or supplies provided to the patient for purposes of administration, review, investigation or evaluation of coverage claims and utilization of services. I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that Rehabilitation Medicine Physicians may use and disclose my Protected Health Information for purposes of treatment, payment, and health care operations. A copy of the document Protected Health Information (PHO) is available to you in the reception area, on our website www.truongrehab.com, or on request from us directly. I also acknowledge that I have received, have been offered, or have received in the past, a copy of the practice's Notice of Privacy Practices (NoPP) which provides information about how the practice and individuals involved in my care in the practice may use and disclose my Protected Health Information. As stated in the NoPP, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540) 374-3164.

I understand that I have the right to request that the practice restrict how my Protected Health Information is used or disclosed for treatment, payment, or health care operations, but I also understand that the practice is not required to agree to a requested restriction. However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the practice, or individuals involved in my care in the practice, have already used or disclosed Protected Health Information in reliance on my prior consent.

Signature of Patient or Guardian: _____Date____/____/____

Office Staff Signature: _____Date ____/____/____

Allergies (circle if yes)

None Novocaine Iodine Latex

Medication allergies and adverse reactions _____

Medications / Prescription Drugs

List all the medications you are taking (including over-the-counter medications, herbs, supplements, etc.)

Medications	Dosage	Frequency	Prescribing Dr.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Supplement Assessment

Do you take supplements? _____ Why or why not?_____ If yes, how do you select your supplements? _____

Estimated monthly supplement cost: _____ Are your supplements working? _____ How do you know? _____

Besides your number one health concern, please circle any additional concerns that you may have:

Bone and Joint Strength Immune System Premature Aging

Cancer Inflammation Sleep Patterns

Diabetes Mental Acuity Stress

Energy Levels Mood Swings Vision (AMD)

Heart Disease Periodontal Health Weight Issues

Commitment to Improving your Health

Low Commitment Medium Commitment High Commitment Just Don't Know

Social History

Status: Single, Married, Divorced, Partnered, Widowed ___ Retired, ___ Working: _____ hrs/week

Currently living with: _____ On disability? No Yes When? ___/___/_____

Have you ever smoked? No Yes Alcohol use: Never, Rarely, Moderate, Daily

If yes, how many / day:____ Quit: ___/___/_____

History of drug abuse: No Yes Highest Education Level Completed:

History of alcohol abuse No Yes _____ Grade Completed _____ High School

____College ____Post Graduate

What is your primary health concern? _____

How are you addressing it? _____ Do you feel what you are doing is working? yes no

How many servings of fresh fruits and vegetables do you eat daily?_____ Are you at your ideal weight? yes no

How often do you exercise for 30 minutes or more per day? 2/wk 4/wk 6/wk

Medical History

Past & Current Medical Conditions:

Diabetes ..... No Yes High Blood Pressure ..... No Yes
Cancer (type: _____) ..... No Yes Stroke ..... No Yes
Heart Arrhythmia (atrial fibrillation) ..... No Yes Arthritis/gout ..... No Yes
Seizure.. ..... No Yes Bleeding tendency ..... No Yes
Hereditary defects, (type:_____) ... No Yes Venereal Disease ..... No Yes
Circulation problems ..... No Yes Asthma ..... No Yes
Emphysema ..... No Yes Thyroid Disease (low-high).....No Yes
High Cholesterol ..... No Yes Fibromyalgia.....No Yes
Endometriosis..... No Yes Heart attacks..... No Yes
Hepatitis (A,B,C).....No Yes Cataract.....No Yes
Ulcer (Stomach, Duodenum).....No Yes Glaucoma.....No Yes
Hemorrhoids.....No Yes Multiple Sclerosis.....No Yes
Lupus.....No Yes
Other: _____
_____

Past surgeries: (List date & reason)_____
_____
_____
_____
_____

Hospitalizations: (List date & reason)_____
_____
_____
_____

Family Medical History Check all that apply

	Family Members	Diabetes	Hypertension	Heart Disease	Stroke Illness	Mental	Cancer	Unknown	Deceased
Father									
Mother									
Children									
Siblings									

Siblings: # of brothers ____ # of sisters ____ Healthy
Children: # of sons ____ # of daughters ___ Healthy

Review of Systems: Patient to Complete - Circle if Applicable

Constitutional	Appetite Change Weight Change Fever Fatigue
Skin	Itching Rash Cancer
Eye, Ear, Nose, Throat, Mouth	Vision Changes Headaches Dizziness Hearing Loss Ringing Ears Swollen Glands
Respiratory	Cough Wheezing Blood in Sputum Lung Cancer Difficulty Breathing
Cardiovascular	Chest Pain Palpitations Swelling in Legs
Gastrointestinal	Nausea Vomiting Diarrhea Constipation Ulcer Bloody Stool Bowel Incontinence Difficulty Swallowing
Genitourinary	Frequency Decreased flow/force/dribbling Painful Urination Kidney Stones Blood in Urine Urinary Incontinence
Endocrine	Diabetes Thyroid Disease Steroid Use Heat/Cold Intolerance
Musculoskeletal	Joint Pain Muscle Pain Stiffness Back Pain Weakness Difficulty Walking
Neurologic	Headaches Paralysis Stroke Seizures Head Injury Numbness Tingling Tremors Difficulty Speaking
Psychiatric	Anxious Depressed Stress Insomnia Tearfulness
Hematological	Anemia Bruise Easily Slow Healing Phlebitis Blood Transfusion
Other Systems	Blood Clots in Legs
Comments	Abnormal Mammogram _____/_____/_____ Bone Fractures _____/_____/_____
8	

History of Presenting Problem:

Referring physician: _____
Primary care physician: _____
Reasons for today's visit: _____
What other physician(s) have you seen for this condition? _____
_____ When? ____/____/_____
_____ When? ____/____/_____
Have you had any type of therapy for this condition?
_____ When? ____/____/_____
_____ When? ____/____/_____
Have you received any medications/injections for this condition? If Yes, What?/When?_____
_____
How did you hear about us? _____
Where is the pain/problem? _____
_____
Severity of pain (Scale 1-10):_____ How long have you had this problem? _____Days _____Months
Quality of the pain, describe: _____
_____
When did it start? ____/____/_____ _____
What is the characteristic of your pain? (circle one) dull, sharp, ache, burning, tingling, electric shock
_____
_____
Does it radiate? (circle one) No Yes Where? _____
_____
What do you want to accomplish by my treating you? _____
_____
What time of day is pain the most severe? _____
_____
What do you do to relieve pain? _____
_____
_____
What activity makes the pain worse? _____
_____
Any MRI, CAT scan, X-ray for these conditions? _____When? / / Where?_____
_____When? / / Where?_____
_____

All information is accurate and complete. Signature of Patient or Guardian_____

Informed Consent for Televisit Consultation and Follow up

I am requesting to take part in a telemedicine consultation with Rehabilitation Medicine Physicians and its physicians, associates, technical assistants and others deemed necessary to assist in my medical care through a telemedicine consultation. I understand the following:

1.The purpose is to assess and treat my medical condition.

2.The telemedicine consult is done through a two-way video HIPAA compliant link-up whereby the physician or other health provider at Rehabilitation Medicine Physicians can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.

3.Since the telemedicine consultants may practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me. The Rehabilitation Medicine Physicians and affiliated telemedicine consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

4.I can ask questions and seek clarification of the procedures and telemedicine technology.

5.I can ask that the telemedicine visit and/or video conference be stopped at any time.

6.I know there are potential risks with the use of this technology. These include but are not limited to:

- Interruption of the audio/video link.
- Disconnection of the audio/video link
- A picture that is not clear enough to meet the needs of the consultation.
- Electronic tampering.

If any of these risks occur, the procedure might need to be stopped.

8.In order to participate in the telemedicine program, I agree to pre-pay for these visits at: select one

[ ] $150 for 15 minutes – Prepaid. I understand the service will stop at the 15 minute mark automatically. This fee will not be refundable or applied to future visit if the appointment is cancelled less than 48 business hours. A 5% fee will be assessed for refund if appointment is canceled prior to 48 business hours.

[ ] $300 for 30 minutes (initial consultation) – Prepaid. I understand the service will stop at the 30 minute mark automatically. This fee will not be refundable or applied to future visit if the appointment is cancelled less than 48 business hours. A 5% fee will be assessed for refund if appointment is canceled prior to 48 business hours.

[ ] Copay with Anthem Insurance – Prepaid. I understand the service will stop at the 15 minute mark automatically. This fee will not be refundable or applied to future visit if the appointment is cancelled less than 48 business hours. A 5% fee will be assessed for refund if appointment is canceled prior to 48 business hours.

By signing this consent, I agree to the charges on my credit card or Care Credit. I understand these services are self-pay or bill to Anthem. I, the undersigned patient, do hereby understand and state that I agree to the above consents and I am doing so of my own free will. I understand I can always opt for an in person office visit. I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents.

I volunteer to participate in the telemedicine examination. I authorize Rehabilitation Medicine Physicians and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____ Signature:_____

Printed Name: _____