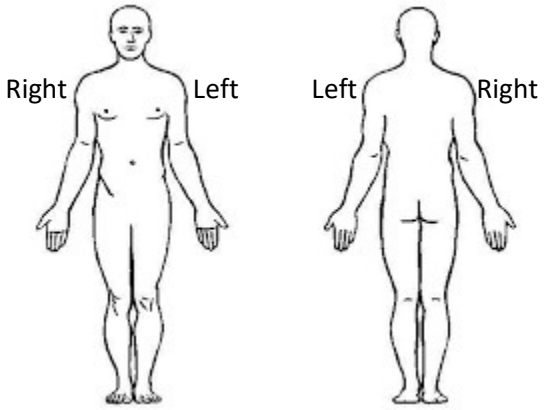
# *Metro Physical Therapy & Chiropractic Center*

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

## Patient Basic Information

| | | |
|---|---|---|
| First Name: | Last Name: | Middle Initial: |
| Address: | City, State, Zip: | |
| Cell Phone: | Work Phone: | Email: |
| Date of Birth: Age: ☐Male ☐Female | Marital Status: ☐Married ☐Single ☐Divorced ☐Separated | |
| Occupation #1: | Employer Name and Address | |
| Occupation #2: | Employer Name and Address | |
| In Case Emergency Contact: | Phone Number: | Relationship: |

Please circle all areas of complaint including any headaches If they are related to or got worse after the accident:
On a scale of 0-10 please indicate the most pain you have had in the past 24 hours since the accident:




What Is Your Condition Due? ☐Motor Vehicle Accident Date of Accident: _____ ☐Work Injury ☐Other

When Did Your Pain Start? Are Feeling ☐Worse ☐Same ☐Better ☐Comes & Goes with Activities

What Helps Reduce the Pain? ☐Rest ☐OTC / Rx Pain Meds ☐ Hot / Cold Packs ☐Hot Showers ☐Other:

Have You Seen Any of The Following for This Condition? ☐Hospital ☐Urgent Care ☐Family Doctor
☐Chiropractor ☐Physical Therapist ☐Massage Therapist ☐Acupuncture ☐Other:
Facility Name and phone number: Date Consulted:

Are you taking any over the counter or prescription medication for your pain? Who prescribed it?

Are you currently under the care of any doctor for <u>any other</u> condition? Are you taking any medication for other condition? Who prescribed it?

Have you lost time from school or work due to your condition? ☐Yes ☐No From: _____To: _____

Do you think you may be pregnant at this time? ☐Yes ☐No Any cardiac pacemakers? ☐Yes ☐No

Patient / Parent / Legal Guardian Signature: Date:

# *Metro Physical Therapy & Chiropractic Center*

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

## Accident Information

First Name: Last Name: Middle Initial:

Briefly Describe the Accident:

**Your vehicle type and year:**

☐Car
☐Mini Van
☐SUV
☐Station Wagon
☐Pick Up Truck
☐Bus
Other:

**Your position in the vehicle:**

☐Driver
☐Front Passenger
☐Left Rear Passenger
☐Right Rear Passenger
☐Mid Rear Passenger
Other:
Was anyone else with you?
☐Yes ☐No

**Your vehicle at the time of the accident?**

Stopped at ☐Intersection ☐Traffic
☐Light ☐Parked
☐Making a right turn
☐Making a left turn
☐Proceeding along
☐Slowing down
☐Accelerating
Other:

**Details of the accident:**

**Who hit who or what?**

Did you hit another car? ☐Yes ☐No
Did another car hit you? ☐Yes ☐No
Did you hit an object? ☐Yes ☐No

**Point of impact?**

☐Front
☐Rear-End
☐Driver's side
☐Passenger's side
☐Other:

Any broken windshields / windows? ☐Yes ☐No
Did air bags deploy? If yes which side? ☐Yes ☐No
Do you have a trailer hitch? ☐Yes ☐No
Other Information:

**During the accident:**

Did you head or body strike inside the vehicle? ☐Yes ☐No
Did you lose consciousness? For how long? ☐Yes ☐No
Where you shaken or shocked after the accident? ☐Yes ☐No
Any cuts or bruises or seatbelt marks on your body? ☐Yes ☐No

**After the accident:**

Where did you go after the accident? ☐Urgent Care ☐Hospital ☐Primary Care Doctor ☐Home ☐Work
Name of the hospital / clinic?
How did you get there? ☐Drove Self ☐Somebody Else ☐Ambulance ☐Police ☐Taxi / Uber / Lyft
Where X-rays done? ☐Yes ☐No Which body parts were X-rayed?
Any Fractures? ☐Yes ☐No What Were the Findings of the Examination?
Did any provider give you a disability slip to be off work or school? ☐Yes ☐No From: To:
Did they give you any medication for your injuries? ☐Yes ☐No

Did you see the accident coming? ☐Yes ☐No Did you braced for the impact? ☐Yes ☐No
Do you have a seat belt on? ☐Yes ☐No
How were you holding the steering wheel? ☐Both hands ☐Left Hand ☐Right Hand ☐None
Your head position at the time of the collision? ☐Straight Forward ☐Turned to the right ☐Turned to the left

Patient / Parent / Legal Guardian Signature: Date:

# *Metro Physical Therapy & Chiropractic Center*

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

## Medical History

First Name: Last Name: Middle Initial:

**Please indicate self or immediate family, date diagnosed, also indicate if under medical care for the conditions listed:**

☐Heart Disease / pacemaker?
☐heart Attack if yes, when
☐Hypertension / taking any medication?
☐Stroke if yes, when
☐Diabetes / taking any medication?
☐Cancer if yes, when and what regions
☐Surgeries / metal in the body? if yes, when and what regions
☐Fractures / Dislocations if yes, when and what regions

**History of Allergies** ☐None ☐Seasonal ☐Medication ☐Other

Smoker? ☐Yes ☐No Play any sports? ☐Yes ☐No Stomach sleeper? ☐Yes ☐No

**Job Title / Description:** **Job Title / Description:**

**Work Duties:** ☐prolonged sitting ☐prolonged standing ☐lifting ☐bending ☐climbing ladder / stairs ☐push / pull

**Previous Accident / Injury History**

Did the patient have any of the symptoms immediately before the accident? ☐Yes ☐No
If yes when and what regions? Any medical care for the symptoms?
Did the patient have any prior sport, auto or work injuries? ☐Yes ☐No
If yes when and what regions? Any medical care for the injuries?
Was the patient at full function just prior to this accident? ☐Yes ☐No

**Other Symptoms: Neuro/Psych Symptoms**

☐Difficulty sleeping if yes, due to:
☐Nervousness
☐Easily irritated and frustrated
☐Decreased or increased appetite
☐Depressed
☐Difficulty remembering old information
☐Short term memory loss
☐Attention or concentration issues
☐Nervousness when in a car
☐Jaw pain
☐Ringing in the ears
☐Blurry vision / double vision
☐Dizziness
☐Fatigue
☐Making more mistakes than usual
☐Slower speed of thinking
☐Bad dreams or flashbacks regarding the accident
☐hypervigilance / hyper alert when in a car after accident

Patient / Parent / Legal Guardian Signature: Date:

# *Metro Physical Therapy & Chiropractic Center*

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

## Authorization to Release Confidential Information

First Name: Last Name:

Address: Date of Birth:

I hereby Authorize (Hospital / Program / Doctor) to release to:

Metro Physical Therapy & Chiropractic Center
121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

The medical records only pertaining to the dates of service: _____, which I understand may include sensitive information such as drug and alcohol information, psychiatric information, HIV information. I understand that this consent is voluntary, and I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken). I may revoke this authorization by written, dated and signed communication to the hospital or program. I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. I authorize the release of any of my medical and billing records reports to be forwarded to Dr. Arash Sarabi, D.C. and from Dr. Arash Sarabi, D.C. to any other entity or individual via fax, email or U.S. mail. If you do not want us to discuss your medical information including your appointment time and date with anyone including your spouse or your family members, please let us know at this time.

Patient / Parent / Legal Guardian Signature: Date:

Witness Signatu Date:

If signed by other than patient, state relationship and reason why the patient could not sign:

Verbal consent requires signature of 2 witnesses:

Signature of Witness Date Signature of Witness Date

Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and will no longer be protected by Health Insurance Potability & Accountability Act.

# *Metro Physical Therapy & Chiropractic Center*

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

**Authorization to Release Payments to the Doctor**

I hereby irrevocably authorize:

Insurance company:

---

Claim Number:

---

To pay all payments of medical bills at Metro Physical Therapy & Chiropractic Center directly to them and not to anyone else. Please mail all payments directly to their address and made payable to:

Metro Physical Therapy & Chiropractic Center
121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

Patient / Parent / Legal Guardian Signature: Date:

# *Metro Physical Therapy & Chiropractic Center*

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

## Patient Contract

We at Metro Physical Therapy & Chiropractic Center would like to take this opportunity to welcome you to our facility and thank you for making us your healthcare provider. If you are happy with the services provided to you in our office, please take a couple of our cards and brochures and refer your family, friends and coworkers who may be in need of our services. Your referrals are highly appreciated.

**Scheduling.** For us to deliver the best possible care, it is important that you arrive for your scheduled appointment on time. Not only this makes our office run smoother, it also allows us to provide you with the attention you deserve. If you are unable to make it to scheduled appointment, please contact our office as soon as possible (preferably at least 24 hours in advance) to reschedule. Prior to leaving the office, make sure you have your next appointment at the front desk. Please be advised that if you show up unscheduled or outside of your scheduled appointment time, we reserve the right to refuse treatment to you. We will however make an effort to see you.

**Auto Accidents.** If you are coming to our office as a result of an auto accident, we are asking that you please bring the PIP application mailed to you by your insurance company as soon as possible so that we can make a copy for your file.

**Instructions:**

1. Perform the therapeutic home exercises as prescribed (number of repetitions and number of times per day). For your convenience we have illustration pages of the exercises available.
2. Avoid activities that aggravate your symptoms (prolonged sitting, standing, lifting or bending).
3. Take your medication as prescribed by your doctor.
4. Notify the clinic of any changes in your symptoms, including new complaints, falls, other accidents or injuries.
5. Notify the clinic of address or phone number changes.
6. Go to an emergency room immediately if any of the following symptoms occur:
    a. Sudden dizziness, blurred vision or vomiting.
    b. Sudden weakness in the arms, hands or legs.
    c. Sudden numbness, tingling or loss of feeling in your arms or legs.

We thank you in advance for your cooperation,

By signing below you affirm that you have read and will abide by the terms set forth in this contract.

Patient / Parent / Legal Guardian Signature: Date:

# *Metro Physical Therapy & Chiropractic Center*

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

## Consent to Chiropractic and Physical Therapy Examination and Treatment

I hereby authorize Metro Physical Therapy & Chiropractic Center and it's licensed healthcare providers and assistants , based on my complaints and history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments provided manually or with the use of an instrument and other tests and procedures considered therapeutically appropriate. I also wish to rely on the Metro Physical Therapy & Chiropractic Center providers to make these decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic / physical therapy examination and evaluation, the chiropractic adjustment and the other procedures that may be, recommended during the course of my care have been explained and described to my satisfaction. Based on current findings the Metro Physical Therapy & Chiropractic Center providers have discussed my diagnosis and treatment plan, the benefits and expected improvements with the proposed treatment plan and the reasonable alternatives to the proposed treatment plan. They have also explained the cost of my proposed care (or provided me with a current fee schedule and the extent practicable the cost of reasonable alternatives to the proposed treatment plan.

To aid the understanding of my condition and the reasons for the proposed treatment plan, the Metro Physical Therapy & Chiropractic Center providers have answered my questions regarding the planned treatments and the course of care I will receive. Metro Physical Therapy & Chiropractic Center providers have also explained to me that my diagnosis and treatment may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic and physical therapy services is very low, anyone undergoing a chiropractic adjustment or manipulative process should know of rare possible hazards and complications which may be encountered or result during the course of care. These include but are not limited to fractures, stroke and paralysis, damage to the nerves, death, disk injuries, dislocations, sprains and trains, and those which relate to physical aberrations unknown and reasonably undetectable by the doctor. Metro Physical Therapy & Chiropractic Center will make every reasonable effort during the examination to screen the contraindications to care, however, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Metro Physical Therapy & Chiropractic Center doctors will advise me of any material risks on this regard.
2. That neither the practice of chiropractic nor medicine or physical therapy are an exact science and that my care may involve the making judgements based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgement or treatment.
4. The practice does not guarantee as to results with respect any course or treatment.

I have read this consent (or I have had it read to me (and have also had an opportunity to ask questions about the consent and understand to satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by Metro Physical Therapy & Chiropractic Center.

Patient / Parent / Legal Guardian Printed Name: _____

Patient / Parent / Legal Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

# *Metro Physical Therapy & Chiropractic Center*

121 Congressional Lane #403 Rockville, MD 20852
Phone: (240) 418-9239 Fax: (240) 559-0102

## Acknowledgement

By signing below, I agree that I have read and understand all the information provided on this page:

1. **Acknowledgement of Receipt of Notice of Privacy Practices.** I acknowledge that I was provided a copy of the notice or privacy practices and that I have read it (or I have had the opportunity to read it if I so choose and I understand the notice).
2. **Financial Responsibility.** It is understood that the statute of limitation in this state is three (3) years since the date the services were performed. It is also understood that because of long delays in trial dockets, many cases are not tried or settled until and date that is three (3) years after the services were performed. Considering this possibility and in exchange for METRO PHYSICAL THERAPY & CHIROPRACTIC CENTER to wait for payment until a verdict is rendered or a settlement is reached, I hereby agree to waive the defense of statue of limitations in the event that a claim is filed against e by the reason of an unpaid bill, and I WILL NOT RAISE THE STATUTE OF LIMITATIONS AS A DEFENSE. If for any reason I decided not to pursue this case or if my attorney drops me or I transfer my case to another attorney, I will immediately notify METRO PHYSICAL THERAPY & CHIROPRACTIC CENTER of the change. It is understood that I responsible for the total balance of my bill regardless of the source of payment or the outcome of my case. METRO PHYSICAL THERAPY & CHIROPRACTIC CENTER expects payment of its fees for services rendered from the proceeds of any recovery. Balances are due and payable within thirty (30) days of any settlement or verdict. Interest at the rate of 18% per annum will be assessed on any balance not paid within thirty (30) days of settlement or verdict. IF IT BECOMES NECESSARY TO PLACE THIS ACCOUNT IN COLLECTIONS, I AGREE TO BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES EQUAL TO 25% OF THE UNPAID BALANCE, TOGETHER WITH ADDITIONAL COSTS AND EXPENSE OF COLLECTION TO THE EXTENT PERMITTED BY LAW.
3. **Release of information to my attorney, other providers, and insurance companies:** I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, my other providers and attorneys involved in this case. I hereby release this clinic of the consequence thereof.
4. **Power of Attorney. I give my power of attorney to** METRO PHYSICAL THERAPY & CHIROPRACTIC CENTER to endorse and / or negotiate checks made payable in my name from insurance companies and / or other entities in regards to the services that were rendered to me by providers at METRO PHYSICAL THERAPY & CHIROPRACTIC CENTER. Such payments are intended for the benefit of METRO PHYSICAL THERAPY & CHIROPRACTIC CENTER.

Patient / Parent / Legal Guardian Signature: Date: