Advanced Physical Therapy

Patient Information

Therapist: ____________________ Account Number: _________

Social Security #: _______________________________________ Sex: ____M ____F

Patient Name: (Last) ______________________________ (First) _________________________________ (MI) ________

Address: ______________________________ City: ______________________ State: _______ Zip: ______

Phone: Home ( )_________________________ Work: ( ) ____________________________

Cell: ( ) ________________________________ E-Mail Address: ___________________________

Date of Birth: _______________________ Marital Status ___M ___S ___D ___W

Patient Employer Name: ______________________________________

Occupation: ____

Emergency Contact Name: _______________________ Phone: ___________________________

Referring Physician: _______________________________________

Have you received physical therapy this year?_____Y_____N
Are you currently receiving home health? ________Y_____N

Responsible Party Information* (Name on insurance card)

**If different than information above*

(Always "Self" for Medicare) (Always "Other" for Workman's Comp.)

Relation to Patient: ___Self ___Spouse ___Parent ___Other

Name: Last ______________________________ First ____________________________________ MI ________

Address: ______________________________City: ___________________State______ Zip______

Phone: Home ( )_____________________ Work: ( )___________________ Ext:_____

Date of Birth_______________________ SSN: ______-_____-_________ Sex: ____M ____F

Employer: __________________________ Address: _____________________________________

City: _______________________________________ State: _________ Zip: __________________

Assignment of My Benefits

For PPO. POS, Med-Pay, PIP, Lien, and Private Third Party Payers.

I hereby instruct and direct ____________________________ insurance company to pay by check made out and mailed to:

Advanced Physical Therapy of Little Rock 10014 N. Rodney Parham Ste. 100 Little Rock, AR 72227

If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

*(Please read and **INITIAL** each statement below and sign at the bottom)*

___ A photocopy of this Assignment shall be considered as effective and valid as the original.

___ I authorize the release of any medical or other information pertinent to my case to any insurance company adjuster.

___ I understand that I am financially responsible for all charges whether or not paid by insurance.

___ I understand that I am responsible to pay any co-pay and/or co-insurance at the time services are rendered and if I have an unmet deductible, I understand that I may be asked to make payments toward said deductible on each visit.

Dated this __________ day of ____________________________, 20____.

_________________________________ **Signature of Policyholder**

_________________________________ **Signature of Claimant, if other than Policyholder**

PLEASE PROVIDE INSURANCE CARD AND DRIVER'S LICENSE TO BE COPIED FOR OUR RECORDS

Informed Consent Agreement — *MUST* be completed prior to treatment.

I hereby indicate my wish to participate in the physical therapy treatment programs offered by Advanced Physical Therapy
I understand that the purpose of this program is to enhance my overall health and fitness.
I understand that dosed exercise may include aerobic conditioning, resistance training, and balance/proprioceptive training to provide cardiovascular conditioning, muscular strengthening, increased joint range of motion, and improved balance.
I understand that dosed exercise may challenge the muscle tissue, which can lead to a temporary and expected level or soreness.
I verify that my participation is fully voluntary and no coercion of any sort has been used to obtain my participation.
I have read the above information and I understand it fully and my questions concerning physical therapy procedures have been answered to my satisfaction.
I understand that I am free to deny answering any questions during the evaluation process or to withdraw from the program at any time.
I understand that the information that is obtained from this process is considered to be confidential and my respected health information is protected fully as outlined in the Statement of Privacy Notice presented to me.

____

Patient's Signature **Date**

____

APTC Representative Signature **Date**

Durable Medical Equipment

During the course of your treatment your therapist **may** issue you one or more items that **will not** be covered by your insurance. These items are known as "Durable Medical Equipment" or "DME." We ask that on the day you are issued any durable medical equipment that you stop by the front desk and pay for the item(s) or make payment arrangements if necessary.

Patient's Signature______________________________Date_________________

Pelvic Floor Patients Only:

Your treatment will require the use of an internal electrode that will not be covered by your insurance. The cost of this equipment is a one-time charge of $50.00. We ask that you pay for this electrode in full by your exam date. If this is not possible, then please make payment arrangements with the front office on your first visit.

Item	Price
Temporary Orthotics	$20
Heel Lift	$12
Maternity SI Belt	$45
SI Belt	$38
Postural Support	$35
Slippery Stuff	$ 9
Biofreeze	$10
Knee Stabilizer	$35
Stimtrode	$15
Custom Orthotics	$250
XLarge Ice Pack	$28
Cervical Ice Pack	$18
Stim Unit Rental (per month)	$50
Postpartum Support	$35
Lymphedema Supplies/Garments	*Subject to necessity

*This is not an inclusive list; other equipment may be issued based on individual needs.

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows*" and late cancellations** inconvenience those individuals who need access to medical care. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments and provide the best care for all our patients.

We do not charge a fee for cancelled appointments but if it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. We understand that there may be times when you must miss an appointment due to an emergency or other obligation. However, when you do not call to cancel an appointment you may be preventing another patient from getting much-needed treatment.

In order for your treatment to be most effective, it is essential that you are consistently here on time for all your appointments. If you are running late, please call our office so we can make sure your therapist will still be able to treat you.

If you miss three appointments as a "no-show" or late cancellation, it will be necessary to discuss the discontinuation of your treatment until you can commit to keeping your scheduled appointments.

*A "no-show" is a patient who misses an appointment without calling to cancel. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

**A late cancellation is when a patient fails to cancel their scheduled appointment with a 24 hour notice.

How to Cancel Your Appointment

To cancel appointments, please call the front office. If you do not reach the office staff, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and offer you the next available appointment time.

I have read and understand the cancellation policy.

____ ________________

Signature Date

Name:___________________________

Current Medication

Please list all medications you are currently taking.

1. Name of Medication:_______________________________________
   Dosage:____
   Frequency:____
   How do you take your medication? (Orally, injection, etc.)______
   ____
2. Name of Medication:_______________________________________
   Dosage:____
   Frequency:____
   How do you take your medication? (Orally, injection, etc.)______
   ____
3. Name of Medication:_______________________________________
   Dosage:____
   Frequency:____
   How do you take your medication? (Orally, injection, etc.)______
   ____
4. Name of Medication:_______________________________________
   Dosage:____
   Frequency:____
   How do you take your medication? (Orally, injection, etc.)______
   ____
5. Name of Medication:_______________________________________
   Dosage:____
   Frequency:____
   How do you take your medication? (Orally, injection, etc.)______
   ____
6. Name of Medication:_______________________________________
   Dosage:____
   Frequency:____
   How do you take your medication? (Orally, injection, etc.)______
   ____
7. Name of Medication:_______________________________________
   Dosage:____
   Frequency:____
   How do you take your medication? (Orally, injection, etc.)____

Advanced Physical Therapy

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing you rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with the restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this constant.
- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

May we phone, e-mail or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

Information that may be disclosed? (circle all that apply): Medical Records Billing

If YES, please name the members allowed:

____

List any other individuals or organizations this information may be released to:

____

Information is being disclosed for the following purpose(s): ___________________________________

Unless otherwise revoked, this authorization will expire two (2) years from the dates this authorization is signed.

This consent was signed by: (**Please Print**) ____

Signature: ____ Date: _________________

If Signed by legal representative, relationship to patient: _________________ Date: _________________

Witness: ____ Date: _________________

Advanced Physical Therapy
Patient History Questionnaire

Name: __________________________ DOB: ______________ Date: _________________

Height: _________ Weight: ____________

Describe the current symptoms that bring you to our clinic:

____
____
____

When did your symptoms first begin? Have they gotten worse or better since that time?

____
____
____

How has your quality of life been changed since your symptoms began?

____
____
____

<u>What treatment have you had for your symptoms? (Check all that apply):</u>

❒ Medication: ____. Did this help? ❒ Y❒ N

❒ Surgery: ____. Did this help? ❒ Y❒ N

❒ Physical Therapy: ____. Did this help? ❒ Y❒ N

❒ I have not had treatment for this problem.

<u>GENERAL HEALTH</u>

How many 8 oz glasses of water do you consume per day? _______

Please list all other fluids you consume, along with amount:

____
____
____

Current level of stress ❒ High ❒ Medium ❒ Low

Have you ever experienced physical, emotional, or sexual abuse? ❒ Yes ❒ No

Current psychiatric therapy ❒ Yes ❒ No

Do you engage in exercise? ❒ Yes ❒ No **If so, describe type and frequency:**

____
____
____

Please check all that apply regarding your medical history:

❒Type II Diabetes ❒Cardiovascular Disease ❒Low back pain ❒Chronic cough/COPD

❒Auto-immune disease ❒Other, please describe: ____

Please check all that apply regarding your surgical history:
❒ Back/spine ❒ Brain ❒ Bladder/Prostate ❒ Bones/joints ❒Abdominal organs ❒Pacemaker/Defibrillator
❒ Other, please describe: ____

URINARY HISTORY (Check all that apply):
Do you:
❒ Urinate more than once every 2 hours
❒ Have a sense of "urgency" to urinate
❒ Have difficulty initiating a urine stream
❒ Have a slow/intermittent stream of urine
❒ Have an odor associated with urine
❒ Have painful urination
❒ Have Interstitial Cystitis
❒ Have chronic urinary tract infections
❒ Wake to urinate
❒ Have difficulty emptying your bladder completely
❒ Leak urine

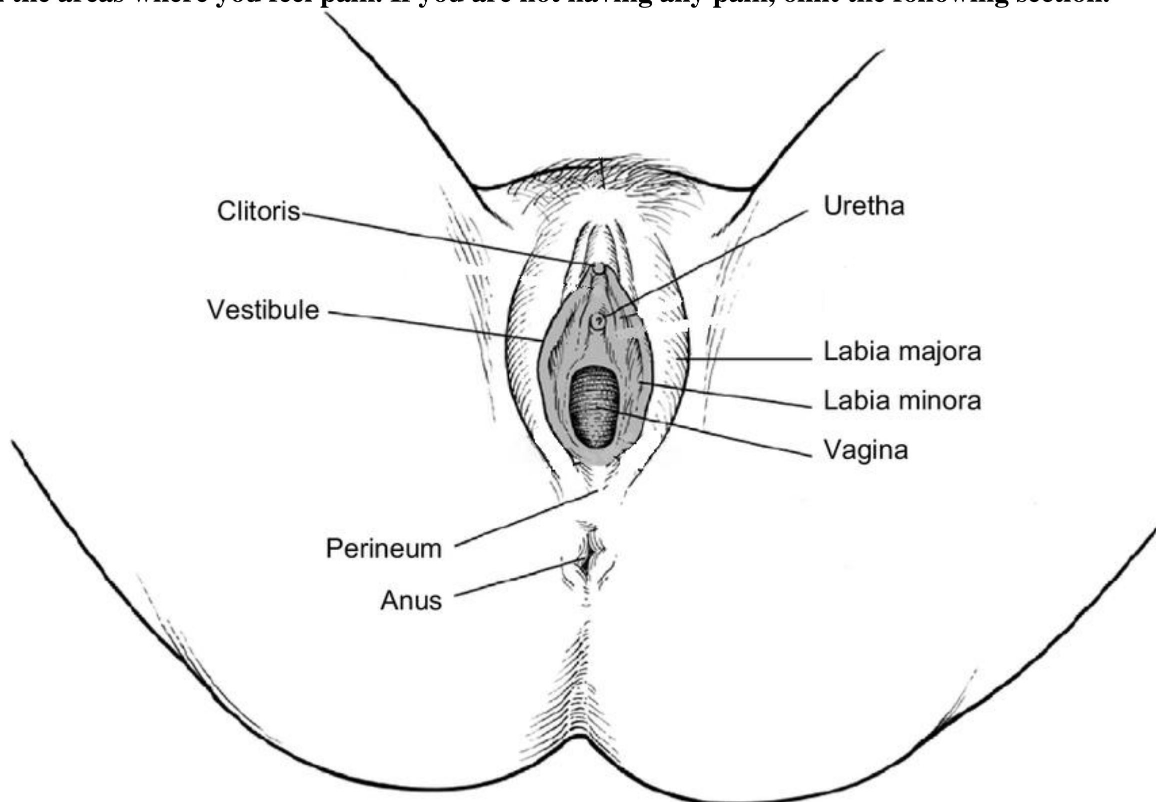
BOWEL HISTORY (Check all that apply):
Do you:
❒ Have daily bowel movements
❒ Have constipation (< 3 bowel movement per week)
❒ Use laxatives regularly
❒ Consume daily fiber supplements
❒ Have pain during bowel movements
❒ Have Irritable Bowel syndrome
❒ Require straining to empty bowels
❒ Leak gas or feces

Number of bladder or bowel leakage episodes per day: Bladder: _______Bowel: _______
On average, how much urine or stool do you leak? ❒ a few drops ❒ wets underwear ❒ wets outerwear ❒ wets the floor
What form of protection do you wear? Please note how many changes are required in 24 hours
❒ Tissue paper/thin liner _____ ❒ Maxi pad _____ ❒ Continence brief______

OBSTETRIC/GYN HISTORY
Are you currently pregnant? If so, when is your due date? ❒ Yes _______________ ❒ No
Date of last pap smear: __________ Date of last period: ________________
Number of pregnancies: _____ Number of vaginal deliveries: ____ Number of Cesarean deliveries: ____
Number of difficult child births: ____ Number of episiotomies or vaginal tearing: ____
Please check all that apply:
❒ Menopause ❒ Painful periods ❒ Feeling that something is "falling out" of the pelvis
❒ Vaginal dryness/itching ❒ Pelvic or vulvar pain ❒ Problematic abdominal or Cesarean scar
Do you have a history of any of the following? (Check all that apply):
❒ Yeast infections ❒ Lichens Simplex ❒ Urinary tract infections
❒ Candida ❒ Lichens Sclerosis ❒ Eczema
❒ Genital Herpes or other STIs ❒ Recent change in vaginal discharge ❒ Contact dermatitis
❒ Psoriasis ❒ Other skin diagnoses: _____________________________

CURRENT SEXUAL ACTIVITY
❒ Sexually active ❒ Sexually inactive due to pain ❒ Sexually inactive due to other reasons
If you are sexually active, continue with this section (check all that apply):
Are you using a form of birth control? If so, please list the type and duration of use ❒ Yes ❒ No
____
❒ No pain with intercourse
❒ No pain during intercourse, but will occur afterwards
❒ Pain with intercourse, but able to complete sex
❒ I can tolerate oral or manual stimulation only
❒ Pain with intercourse prevents sex

Please mark the areas where you feel pain. If you are not having any pain, omit the following section.



Please rate your pain on a scale from 0 - 10, with 0 being no pain and 10 being the worst pain imaginable: ______

PELVIC FLOOR DISTRESS INVENTORY

NAME____DATE __________________________

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas but please fill out both sides of this form as completely as possible.

Do you experience, and if yes, how much are you bothered by….	Yes or No	Not at all	Somewhat	Moderately	Quite a bit
Usually experience pressure in the lower abdomen?	No Yes →				
Usually experience heaviness or dullness in the pelvic area?	No Yes →				
Usually have a bulge or something falling out that you can see or feel in your vaginal area?	No Yes →				
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	No Yes →				
Usually experience a feeling of incomplete bladder emptying?	No Yes →				
Ever have to push on the bulge in the vaginal area with your fingers to start or complete urination?	No Yes →				

Do you experience, and, if so, how much are you bothered by…	Yes or No	Not at all	Somewhat	Moderately	Quite a bit
Feel you need to strain too hard to have a bowel movement?	No Yes →				
Feel you have not completely emptied your bowel at the end of a bowel movement?	No Yes →				
Usually lose stool beyond your control if your stool is well formed?	No Yes →				
Usually lose stool beyond your control if your stool is loose?	No Yes →				
Usually lose gas from the rectum beyond your control?	No Yes →				
Do you usually have pain when you pass your stool?	No Yes →				
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	No Yes →				
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	No Yes →				

Do you experience, and if so, how much are you bothered by...	Yes or No	Not at all	Somewhat	Moderately	Quite a bit
Usually experience frequent urination?	No Yes →				
Usually experience urine leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom?	No Yes →				
Usually experience small amounts of urine leakage related to coughing, sneezing, or laughing?	No Yes →				
Usually experience small amounts of urine leakage (that is, drops)?	No Yes →				
Usually experience difficulty emptying your bladder?	No Yes →				
Usually experience pain or discomfort in the lower abdomen or genital region?	No Yes →				

Urinary Distress Inventory 6 (UDI-6)