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.

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 Health Questionnaire**

*Patient Name:*_____ *Date:*_____

*1. Describe your symptoms:*_____

_____

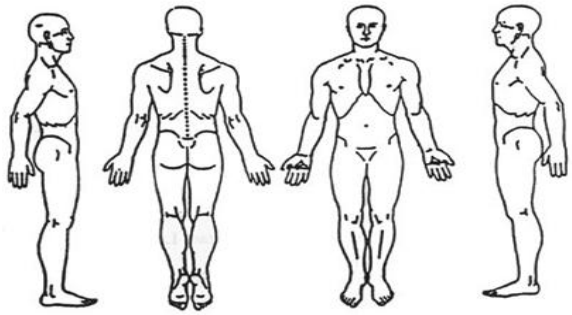
A. When did your symptoms start? _____

B. How did your symptoms begin? _____

*Height:*_____ *Weight:*_____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms using "x"

_____Constantly (76-100% of the day)
_____Frequently (51-75% of the day)
_____Occasionally (26-50% of the day)
_____Intermittently (0-25% of the day)



3. what describes the nature of your symptoms?
____Sharp ___shooting
____Dull ache ___burning
____numb ___tingling

4. how are your symptoms changing?
_____Getting better _____Not changing Getting worse

5. During the past 4 weeks: ***none*** ***unbearable***
A. Indicate the average intensity of your symptoms (circle one) 0 1 2 3 4 5 6 7 8 9 10

B. How much has pain interfered with your normal work (including both work outside the home and housework)?
___Not at all ____A little bit ___Moderately _____Quite a bit ____Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
___All of the time ___Most of the time ___Some of the time ___A little of the time ___None

7. In general, would you say your overall health right now is….
___Excellent ____Very Good ___Good ____Fair ____Poor

8. Who have you seen for your symptoms? ____No one ____Medical doctor ____Other
____Chiropractor ____Physical Therapist

A. What treatment did you receive and when? _____

B. What tests have you had for your symptoms ____X-rays date:_____ ___CT Scan date:_____
And when were they performed? ____MRI date:_____ ___Other date:_____
9. Have you had similar symptoms in the past? _____YES _____NO

10. What is your occupation? _____

A. What is your current work status? ____Full time ____Self employed ____Off work
____Part-time ____Unemployed ____Other

Patient Signature:_____Date:_____

Have you ever been diagnosed with or experienced any of the following? (check all that apply)

- ▢ Alzheimer's disease
- ▢ Anemia
- ▢ Asthma
- ▢ Cauda equina syndrome
- ▢ Current or recent infection
- ▢ Depression
- ▢ Diabetes Mellitus Type 1
- ▢ Diabetes Mellitus Type 2
- ▢ Dizziness/lightheadedness
- ▢ Epilepsy
- ▢ Fibromyalgia
- ▢ Fracture/suspected fracture
- ▢ Headaches
- ▢ History of cancer
- ▢ Huntington's Disease
- ▢ Immunosuppression
- ▢ Lupus
- ▢ Muscular dystrophy
- ▢ Obesity
- ▢ Osteoarthritis
- ▢ Parkinson's Disease
- ▢ Recent falls
- ▢ Rheumatoid arthritis
- ▢ Stroke
- ▢ Traumatic brain injury
- ▢ Thyroid problems
- ▢ Unexplained weight loss/gain
- ▢ Other _____
  _____

Cardiac history: (please check all that apply) ▢ Cardiovascular disease ▢ High blood pressure
▢ Pacemaker ▢ History of intermittent chest pain ▢ Blood clots

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Do you smoke? _____ packs/day Do you drink caffeine? _____ cups/day
During the past month have you been feeling down, depressed or hopeless? ▢ Yes ▢ No
During the past month have you been bothered by having little interest or pleasure in doing things? ▢ Yes ▢ No

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1. During the last 3 months, have you leaked urine and/or stool?
   ▢ Yes (continue to question 2) ▢ No (skip question 2 and 3)
2. During the last 3 months, did you leak urine: *(check all that apply)*
   ▢ When performing some physical activity (coughing, sneezing, lifting, or exercise)?
   ▢ When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?
   ▢ Without physical activity and without a sense of urgency?
3. During the last 3 months, did you leak urine *most* often: *(check only one)*
   ▢ When performing some physical activity (coughing, sneezing, lifting, or exercise)?
   ▢ When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?
   ▢ Without physical activity and without a sense of urgency?
   ▢ About equally as often with physical activity as with sense of urgency?
4. Do you have pain and/or pressure in the saddle region? ▢ Yes ▢ No
5. Do you have pain with intercourse? ▢ Yes ▢ No

For women: Are you pregnant or do you think you might be pregnant? ▢ Yes ▢ No
How many pregnancies have you had, if any? _____
How many miscarriages have you had, if any? _____
How many complicated deliveries have you had, if any? _____

Please list any known allergies: _____
_____