

PATIENT INITIAL INFORMATION

Patient Name: _____ Date of Birth: _____ Do you identify as: Male / Female

Social Security Number: _____ Marital Status: _____ Date of Injury: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Employer: _____ Work Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Referring Physician: _____ Claim Number (If worker's comp) _____

People with whom we may discuss your medical care: _____

Email Address: _____

Would you prefer to be notified, regarding your appointment, via: text message, e-mail message, or telephone. Please circle.

Primary Insurance _____ Insured Person _____ Insured DOB _____
Please indicate insured's relationship to patient: Self / Spouse / Parent

Secondary Insurance _____ Insured Person _____ Insured DOB _____
Please indicate insured's relationship to patient: Self / Spouse / Parent

Have you had any therapies-physical, occupational or chiropractic-in the last twelve (12) months?
If so, where and how many visits? _____

No-Show Cancellation Policy

The following are our policies regarding cancellations and no-shows. Your referring doctor and/or your therapist have established a plan of care that includes the frequency of treatment. Attending your scheduled therapy is very important for you to progress to your goals in treatment.

- **We require 24 hour advanced notice in the event of a cancellation.**
- **There may be a \$25 charge for any no-show appointments.**
- **No-show appointments and appointments that are canceled the same day of the appointment are documented in your medical record and are reported to your referring physician on your next updated progress report to your physician.**
- **For Worker's Compensation and Personal Injury patients, documents of any missed or canceled appointments are forwarded to your case manager and referring physician.**

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Patient Health Questionnaire

Patient's Name _____ **Today's Date** _____

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and your referring physician give you the best possible care. Please answer every question as accurately and thoroughly as you can.

Age _____ **Height** _____ **Weight** _____ **Occupation** _____

Have you had a flu vaccine? Yes _____ No _____. **If yes, when was your flu vaccine:** _____

Have you had a pneumonia vaccine? Yes _____ No _____. **If yes, when was your pneumonia vaccine:** _____

What is your chief complaint? (diagnosis, symptoms, or condition) _____

Medical History (please check if you have any of the following:)

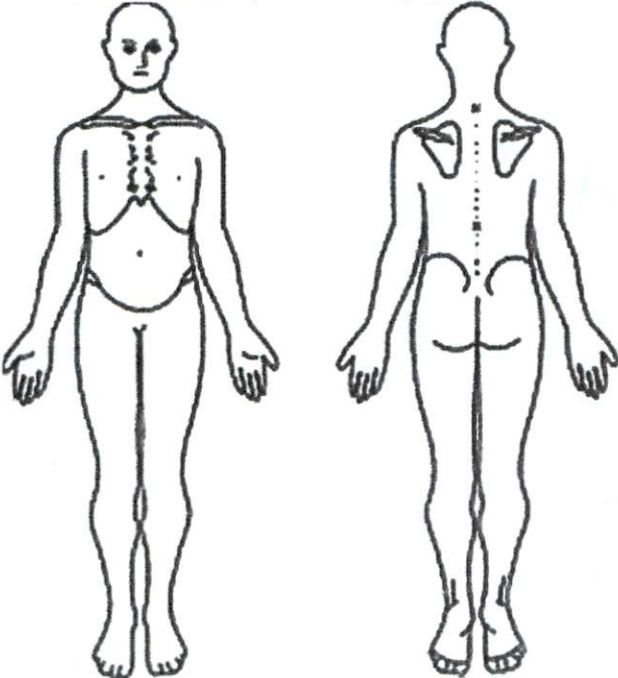
- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hearing Impairments | <input type="checkbox"/> Muscular Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Cardiac Condition | <input type="checkbox"/> Fractures | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> MRSA | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| | | | <input type="checkbox"/> Vision Problems |

If you checked any of the above conditions, please explain and give approximate dates and describe any other conditions not listed above: _____

Is the injury due to a fall? _____ **Have you had 2 or more falls in the last year?** _____

Do you have a fear of falling? _____

Please indicate where you are having symptoms



Please list any medications (with dosage and frequency) you are currently taking: _____

On a scale of 0-10, please rate your pain:

Current pain _____ worst pain _____ best pain _____

When is your pain at its worst? _____

Is it constant or intermittent? _____

How would you describe your pain/symptoms?

- sharp shooting aching dull
 numbness tingling burning
 throbbing other: _____

What tests have you had for this problem?

Xray _____ MRI _____ CT _____ EMG _____

Other: _____

Have you ever had surgery for this problem?(if yes, please list date of surgery) _____

Please list any other surgeries you have had: _____

Please check any activities you are having trouble doing due to your injury or symptoms:

- | | | |
|------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> sleeping | <input type="checkbox"/> bed mobility | <input type="checkbox"/> dressing |
| <input type="checkbox"/> bathing | <input type="checkbox"/> sitting | <input type="checkbox"/> standing |
| <input type="checkbox"/> walking | <input type="checkbox"/> running | <input type="checkbox"/> bending |
| <input type="checkbox"/> housework | <input type="checkbox"/> computer use | <input type="checkbox"/> driving |
| <input type="checkbox"/> jumping | <input type="checkbox"/> changing direction | <input type="checkbox"/> lifting |
| <input type="checkbox"/> squatting | <input type="checkbox"/> reaching overhead | <input type="checkbox"/> stairs |
| <input type="checkbox"/> transfers | <input type="checkbox"/> reaching behind back | |

sport activity: _____

work related activity: _____

other: _____

Advanced Physical Therapy, PLLC

PAYMENT POLICY

We offer, as a service for our patients, the option of billing your insurance. We will contact your insurance company on or near the initial date of service to verify coverage. However, benefit verification is not a guarantee of payment.

DEDUCTIBLES AND CO-PAYMENTS:

Deductibles and co-payments are due at the time of service. Unpaid balances left by your insurance companies will be your responsibility. Please contact our billing specialist if you would like to arrange a monthly payment plan.

FINANCIAL RESPONSIBILITY:

If you do not have any insurance coverage, payment is expected at the time of service. Those accounts not paid in full after 30 days may be listed with a collection agency, unless other arrangements are made. We accept cash, checks and most credit cards.

WORKER'S COMPENSATION:

Patients who are covered under Worker's Compensation are required to provide the following: exact date of injury, claim numbers, billing address and any authorizations required for treatment and/or services to be rendered. You, the patient, or the authorizing party must provide these. If all of the above information is not provided, you, the patient, will be responsible for any charges incurred.

LITIGATION:

Patients who have been involved in an accident have the following billing options: 1) bill your automobile or liability insurance, 2) bill your health insurance or 3) payment in full at the time of service. We will not bill another parties' policy, even if they are responsible for the accident. For any unpaid balance, we will require a good-faith payment from the patient each month until settlement is reached and the account is paid in full. **REMEMBER:** Any unpaid balance will be the responsibility of the patient and subject to listing with a collection agency after 30 days of non-payment.

Patient's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

Advanced Physical Therapy

Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: (Print) _____ **Birth Date:** _____

Signature: _____ **Date:** _____

Initial: _____

This is my authorization of consent for medical services rendered.

Initial: _____

This is my authorization for the release of medical information necessary to process my claim, and/or to obtain medical information from other providers.

Initial: _____

This is my authorization for the insurance company to pay directly to the provider of service.

Initial: _____

I understand and agree I am responsible for balances or services not covered by insurance, attorneys, etc.

Initial: _____

Witness: _____ **Date:** _____



ADVANCED PHYSICAL THERAPY

CONSENT FOR PHYSICAL THERAPY

Date: _____

Time: _____

1. I, _____, am entering Advanced Physical Therapy, PLLC, voluntarily for the purpose of physical therapy treatments, and do hereby consent to such treatment.
2. I hereby authorize advanced Physical Therapy, PLLC, to complete any insurance forms and release any information, be it verbal or written, including the diagnosis and records of any treatment or examinations rendered to me, submitted to them in connection with physical therapy. This authorization is valid unless otherwise revoked, via written form, by myself.
3. I agree the Advanced Physical Therapy, PLLC shall not be liable or responsible for the loss or damage to any articles or personal property having a monetary value.
4. I understand that a payment in full for medical supplies is due at the time of treatment. I understand that payment in full for durable medical supplies is due prior to receipt of the equipment.
5. Advanced Physical Therapy, PLLC will make every effort to provide adequate privacy. If you feel additional privacy is necessary, please inform our staff.
6. This form has been fully explained to me, and I certify that I understand its contents.

****Signature of PATIENT

WITNESS

If the patient is unable to consent or is a minor, complete the following:

___ Patient named above is a minor ___ years of age

___ Patient named above is unable to sign because _____

For this reason I am signing on behalf of the patient named.

Signature of Guardian or Relative

WITNESS