PATIENT INITIAL INFORMATION

Patient Name:_____ Date of Birth:_____ Gender:_____

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

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

Home Phone Number:_____ Cell Phone Number:_____

Email Address:_____

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:_____

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 Cancelation Policy

The following are our policies regarding cancelations 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 cancelation.**
- **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:)

___Allergies
___Anemia
___Anxiety
___Arthritis
___Asthma
___Autoimmune Disorder
___Cancer
___Cardiac Condition
___Cardiac Pacemaker
___Drug/Alcohol Abuse
___Circulation Problems
___Currently Pregnant
___Depression
___Diabetes
___Dizzy Spells
___Emphysema/Bronchitis
___Fibromyalgia
___Fractures
___Gallbladder Problems
___Headaches
___Hearing Impairments
___Hepatitis
___High Cholesterol
___High/Low Blood Pressure
___HIV/AIDS
___Incontinence
___Kidney Problems
___Metal Implants
___MRSA
___Multiple Sclerosis
___Muscular Disease
___Osteoporosis
___Parkinson's
___Rheumatoid Arthritis
___Seizures
___Smoking
___Speech Problems
___Strokes
___Thyroid Disease
___Tuberculosis
___Vision Problems

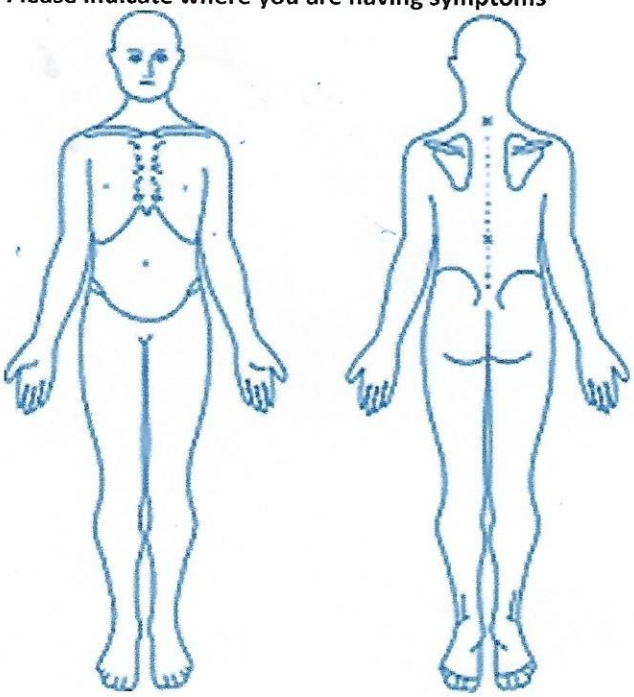
If you checked any of the above conditions, please explain and give approximate dates and describe any other conditions not listed above:_____

_____

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:

___sleeping ___bed mobility ___dressing
___bathing ___sitting ___standing
___walking ___running ___bending
___housework ___computer use ___driving
___jumping ___changing direction ___lifting
___squatting ___reaching overhead ___stairs
___transfers ___reaching behind back
___sport activity:_____
___work related activity:_____
___other:_____

Advanced Physical Therapy, PLLC

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PRACTICE POLICIES

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:

The patient has the following options: 1) bill your automobile or liability insurance, 2) bill your health insurance or 3) payment in full at the time of service. 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's Signature:_____ Date:_____

INFORMED CONSENT: Treatment in the Era of Covid-19

Thank you for your continued trust in our practice. As with transmitting any communicable disease like a cold or flu, you may be exposed to COVID-19, at any time or place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office. Due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, health care providers, staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes____ No_____

_____ _____

Patient/Parent's Signature Date

Advanced Physical Therapy

Privacy Practices

Acknowledgment Form

Name: (Print) _____Birth Date:_____

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

This is my authorization of consent for medical services rendered.

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

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

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

Signature: _____Date:_____

Witness: _____Date:_____

Shared:Privacy practices signature page