

Advanced Physical Therapy

Patient Information

Social Security #: _____ Sex: ___M___F

Patient Name: (Last) _____ (First) _____ (MI) _____

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

Phone: Home () _____ Work: () _____

Cell: () _____ E-Mail Address: _____
_____ *check here to opt out of emails*

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

How did you hear about us? (Circle one) Facebook Instagram Website/Google Doctor
Other: _____

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

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 your 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: _____

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 Patient Health Questionnaire

Patient Name: _____ Date: _____

1. Describe your symptoms: _____

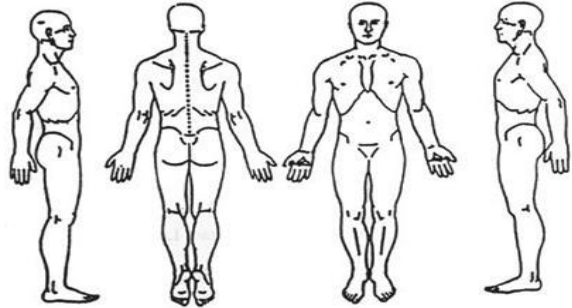
A. When did your symptoms start? _____

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 Chiropractor Physical Therapist

Other: _____

A. What treatment did you receive and when?

B. What tests have you had for your symptoms
And when were they performed?

X-rays date: _____ CT Scan date: _____

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)

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

Cardiac history: (please check all that apply) Cardiovascular disease High blood pressure

- Pacemaker History of intermittent chest pain Blood clots

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

-
- During the last 3 months, have you leaked urine and/or stool?
 Yes (continue to question 2) No (skip question 2 and 3)
 - 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?
 - 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?
 - Do you have pain and/or pressure in the saddle region? Yes No
 - 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: _____
