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
NO SHOW AND LATE CANCELLATION POLICY
(Revised 11/19)

Our desire at Advanced Physical Therapy is for you, the patient, to achieve the best outcome possible. While you will receive outstanding care from our physical therapists, you must be an active participant in your care. Our front office staff will schedule you accordingly, but it is imperative that you keep your scheduled appointments.

Patients who are not able to keep their appointments are asked to provide timely notice of a cancellation to Advanced Physical Therapy. “**Timely notice**” is defined as **at least 24 hours** prior to the appointment.

Patients who arrive **15 minutes or later** past their appointment time will be required to reschedule. This will count as a **cancellation** and applicable fees will apply.

Patients who are unable to keep their appointments and **do not provide at least a 24-hour** notice will be charged a **no show/late cancellation** fee as described below. All **no show/late cancellations fees** that have been assessed to a patient must be paid prior to the patient’s next appointment. These fees will not be added to a patient’s account or invoiced to the patient.

- **First Occurrence:** **NO CHARGE**
- **Second Occurrence:** A $50 fee will be collected before next appointment
- **Third Occurrence:** A $75 fee will be collected before next appointment
- **Fourth Occurrence:** Discharged from treatment

“**No Show”** fees must be paid before a patient’s next scheduled appointment. This fee is not covered by insurance and is not eligible for reimbursement with an HSA or FSA account.

>>

I verify that I have been informed of the NO SHOW/LATE-CANCELLATION POLICY

______________________________ ______________ ______________
Print Patient Name **Patient DOB** **Date**

____
Patient Signature

____
Staff Witness

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?

_____
_____
_____

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

❒ 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.

GENERAL HEALTH

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_____

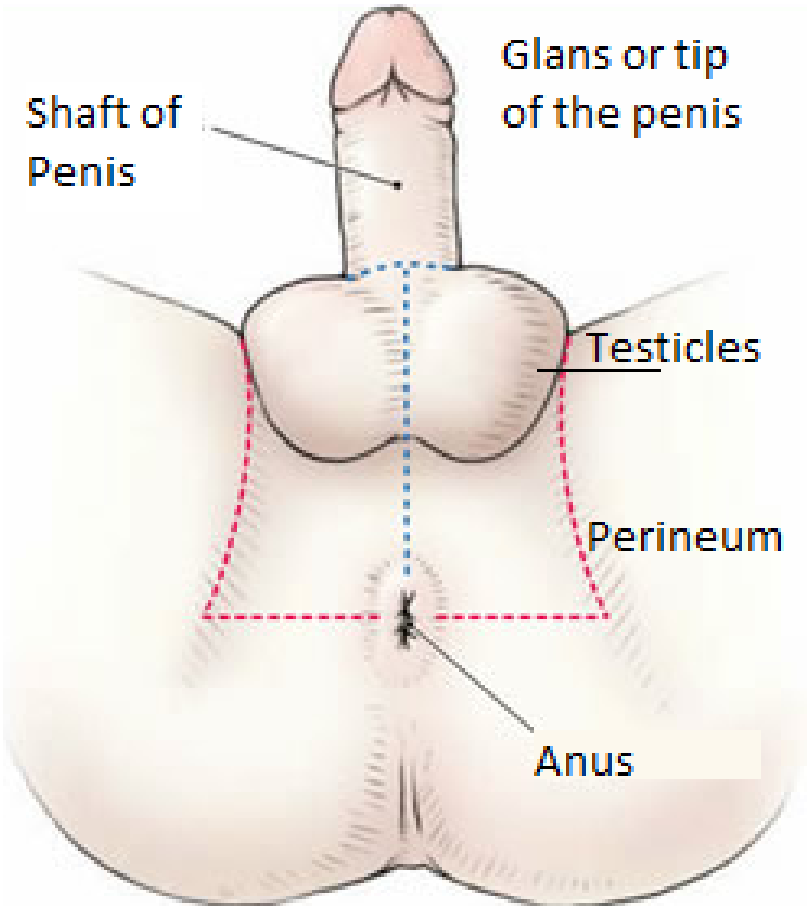
CURRENT SEXUAL ACTIVITY

❒ 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):

❒ No pain with intercourse
❒ Pain with intercourse, but able to complete sex
❒ Pain with intercourse prevents sex at all
❒ Tolerate oral or manual stimulation only
❒ Inability to have an erection
❒ Pain with erection
❒ Painful ejaculation
❒ Cramping after ejaculation

Please mark the areas where you feel pain. If you are not having 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: _____

Urogenital Distress Inventory

Please Circle the response that reflects the symptoms you are currently experiencing and how bothersome they are for you. Please answer all items.

1. Do you experience frequent Urination?

1 Yes
0 No (skip to next question)

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

2. Do you experience night-time urination?

1 Yes
0 No

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

3. Do you experience urine leakage related to The feeling or urgency?

1 Yes
0 No (skip to next question)

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

4. Do you experience urine leakage related to Physical activity, coughing, or sneezing?

1 Yes
0 No (skip to next question)

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

5. Do you experience general urine leakage NOT related to urgency or activity?

1 Yes
2 No (skip to next question)

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

6. Do you experience <u>small</u> amounts of urine Leakage (drops?)

1 Yes
0 No (skip to next question)

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

7. Do you experience <u>large</u> amounts of urine leakage?

1 Yes
0 No (skip to next question)

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

8. Do you experience difficulty emptying your bladder?

1 Yes
0 No (skip to next question)

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

9. Do you experience pain or discomfort in
The lower abdominal or genital area?

1 Yes
0 No

If yes, how much does it bother you?

0 Not at all
1 Slightly
2 Moderately
3 Greatly

TOTAL:_____

Other Symptoms:

_____

_____

_____

Please go back and review all the symptoms listed to the questions. Write the number of the question that impacts you the most. _____

_____

Patient Signature Date