ADVANCE PHYSICAL THERAPY

CERTIFIED POSTURAL RESTORATION CENTER

77 South Elliott Road, Chapel Hill, NC 27514

PATIENT INFORMATION

Patient Name: First _____ Last _____ MI _____

Street Address _____ City _____ State ____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

Email _____ Profession_____

How did you hear about Advance Physical Therapy?_____

How would you like to receive appointment reminders? E-mail **OR** Phone Call: Cell / Home (Circle One)

How would you like to receive financial statements? Postal Mail **OR** E-Mail (Circle One)

Date of Birth _____/_____/_____ Age _____ SS# _____ Gender _____

Emergency Contact Name and Relationship _____

Emergency Contact Primary Phone _____ Alternate Phone _____

Primary Care MD _____ Referring MD (if different) _____

Next appointment with referring MD (if applicable) _____

Medical Diagnosis or Primary Concern: _____

Date of Onset _____ Date of Surgery _____ Date of Accident _____

Name of Insurance Company _____

Policy Holder Name _____ Date of Birth _____

Relationship to Patient _____

CONSENT FOR TREATMENT

I, the undersigned, give permission to the practitioner/s of Advance Physical Therapy, to administer evaluation and treatment necessary and advisable for my condition. (If patient is a minor, a parent or guardian must sign)
Consent must be signed before we begin treatment.

_____ _____

Signature Date

CONSENT FOR EMAIL COMMUNICATION

I, the undersigned, give permission to the practitioner/s of Advance Physical Therapy, to communicate with me via email. I understand that Advance Physical Therapy cannot guarantee the security of Protected Health Information (PHI) via email. Please indicate if you DO NOT want to receive updates about special clinic events.

☐ Yes, I give consent to use email for *Office Communications* (appointment reminders, communication with PT & staff only).

☐ No, I do not give consent to use email for *Office Communications.*

☐ I do not wish to receive updates about special clinic events.

_____ _____

Signature Date

Financial Policy

This is an agreement between Advance Physical Therapy as creditor, and the patient/debtor named on this form. In this agreement the words 'you', 'your', and 'yours' mean the patient/debtor. The word 'account' means the account that has been established in your name to which charges are made and payments credited. The words 'we', 'us' and 'our' refer to Advance Physical Therapy.

By executing this agreement, you are agreeing to pay for all services that are received.

Payments: Unless other arrangements are approved in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. You agree to pay any portion of the charges not covered by insurance.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt.
If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Orange County, North Carolina.

Credit History: We are members of the American Credit Bureau. You give us permission to answer questions about your credit experience with us. We have the option to report your account status to the credit bureau.

Waiver of Confidentiality: You understand if this account is submitted to an attorney if we have to litigate in court, or if your past due status is reported to the credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/ authorization by your employer and/or worker's compensation carrier. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney. In addition, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Signature: _____ Date: _____

Cancellation Policy

- Effective June 1, 2016 there will be a **$40 charge (one hour appointments)** for any *non-emergency* cancellations with less than **48 hour business day** (M-F) notice **by phone** or no-show appointments.
- Effective June 1, 2016 there will be a **$80 charge (two hour appointments)** for any *non-emergency* cancellations with less than **72 hour business day** (M-F) notice **by phone** or no-show appointments.
- When scheduling intensive appointments (ie: more than 1 two hour appointment in one week) there is a **deposit of $40 per hour** required for each appointment. The deposit will be applied to the balance owed for the appointments, or refunded if there is a credit balance after insurance has been processed.
- **Notice to cancel scheduled intensive appointments must be given by phone 5 business days prior to the first scheduled appointment to receive a refund of the deposit paid.**

Signature: _____ Date: _____

Consent for Use and Disclosure of Notice of Protected Health Information

I have read and fully understand Advance Physical Therapy's (APT) Notice of Information Practices. I understand that Advance Physical Therapy may use or disclose my PHI for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that APT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my PHI for purposes as noted in APT's Notice of Patient Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature: _____ Date: _____

Name: _____ Date: _____

MEDICAL HISTORY INTAKE FORM

Have you or an immediate family member ever been told you have the following:
(please circle and indicate relation i.e. "self", "mother", "brother", etc)

Allergies
Angina or chest pain
Anxiety/Panic attacks
Arthritis
Asthma or other breathing problems
Cancer
Chemical Dependency (Drugs, Alcohol)
Cirrhosis/Liver disease
Depression
Diabetes
Eating Disorder (Anorexia, Bulimia)
Headaches
Heart Attack
Hemophilia or slow healing
High Cholesterol
High Blood Pressure
Kidney Disease/Stones
Multiple Sclerosis
Osteoporosis
Scoliosis
Stroke
Tuberculosis
Other (please describe): _____

Do you have any **allergies** to food, medications or latex? _____

HAVE <u>YOU</u> EVER HAD (please circle):

Anemia
Epilepsy/Seizures
Fibromyalgia
Hepatitis/Jaundice
GERD/Ulcers
Gout
Hypoglycemia
Hypo/Hyper Thyroid
Joint Replacement
Parkinson's
Peripheral Vascular
Polio/Post Polio
Rheumatic Fever
Skin Problems
Urinary Problems

FOR WOMEN (please circle):
Endometriosis
Pelvic Inflammatory Disease
Are you pregnant? **Y / N**
# of pregnancies? _____
# of live births? _____

FOR MEN (please circle):
Prostate Problems
Genital Pain / Problems

GENERAL HEALTH:

1. I would rate my health as: ***Excellent*** ***Good*** ***Fair*** ***Poor***
2. Please list all prescription medications: _____
3. Please list over-the-counter medications: _____
4. Please list vitamins/supplements: _____
5. Have you been sick in the last 3 weeks? _____ If yes, describe: _____
6. Have you noticed any lumps or thick skin/muscle anywhere on your body? _____
7. Do you have any sores that have not healed or any change in size, shape, or color of a wart or mole?
   Y / **N** (circle one) If yes, describe: _____
8. Do you smoke or chew tobacco? _____ How much per day? _____ # of years? _____
9. I used to smoke/chew but quit. How much per day? _____ # of years? _____
10. I would like to quit smoking/chewing tobacco? YES NO

Name: _____ Date: _____

11. How many alcoholic drinks do you consume per week? _____
12. How much caffeine do you consume daily (soda, coffee, tea, chocolate)? _____
13. Are you on any special diet? _____
14. Do you currently exercise? **Y** / **N** (circle one) If yes, how often? _____

    If yes, what types? _____
15. How many falls have you had in the past year? _____
16. Describe problems with your balance or fear of falling? _____

    _____
17. Do you have, or have you recently had any of these problems (please check any that apply):

_____ *Blood in urine, stool, vomit, or mucous*
_____ *Dizziness, fainting, or blackouts*
_____ *Fever, chills, day or night sweats*
_____ *Nausea, vomiting, loss of appetite*
_____ *Changes in bowel and/or bladder function*
_____ *Throbbing sensation in belly or elsewhere*
_____ *Skin rash or changes*
_____ *Cough*
_____ *Leaking urine*
_____ *Heart palpitations*
_____ *Numbness or tingling*
_____ *Swelling or lumps anywhere*
_____ *Problems seeing and/or hearing*
_____ *Unusual fatigue or drowsiness*
_____ *Difficulty swallowing or speaking*
_____ *Memory loss*
_____ *Confusion*
_____ *Sudden weakness*
_____ *Trouble sleeping*
_____ *Jaw pain, noise, teeth grinding*

MEDICAL / SURGICAL HISTORY:

1. Have you ever been treated with chemotherapy, or radiation therapy? _____
2. Have you had any X-rays, sonograms, CT scans, MRI, bone scans or other imaging tests done recently? **Y** / **N** (circle one) If yes, what? _____ When? _____

   Results: _____
3. Have you had any lab work done recently? **Y** / **N** (circle one) If yes, results: _____
4. Please describe any other recent clinical tests: _____
5. Please list other providers or treatments for this condition: _____
6. Are you receiving home health services? _____
7. Please list any significant operations that you have had and the dates:

8. Do you have a pacemaker, transplanted organ, breast implant, or other implants? _____

LIVING ENVIRONMENT:

1. Please describe your physical work requirements/exposure to chemicals: _____

   _____
2. Please describe any difficulty with these: _____
3. Who lives with you? _____
4. Do you feel safe in your home? _____

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Certified Postural Restoration Center
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Permission to Photograph and/or Video for Customization of Patient Care

At Advance Physical Therapy we make the effort to customize our patients' treatment program for their specific postures and movement patterns. The use of photo and video assessment during treatment greatly helps us evaluate these components.

We will not use these images for any purpose other than patient treatment unless authorized by the signee via a separate photo release.

I, _____Patient name (or Legal Guardian), grant Advance Physical Therapy, LLC, its representatives and employees the right to take photographs and or video recordings of me for the purpose of customization of patient care and use as indicated by me above.

Patient Name (print) _____

Patient Signature _____

Parent/Guardian Signature (*if patient is under age 18*) _____

Date: _____