ADVANCE PHYSICAL THERAPY

CERTIFIED POSTURAL RESTORATION CENTER

PATIENT INFORMATION

First Name ________________________ MI ____ Last _________________________ Preferred Name _________________

Date of Birth ____ /____ /_____ Age _____ Gender _____________ Patient/Guarantor SS# ________________________

Street Address ____

City ____________________________ State ______ Zip Code __________ Occupation ______________________________

Primary Phone _________________________ Home/Cell/Work Alternate _________________________ Home/Cell/Work

Email Address ____ Marital Status ☐ Single ☐ Married ☐ Other

Emergency Contact Name ________________________________ Phone ______________________ Relationship _____________

How did you hear about APT? ☐ Friend/Family ☐ Referral ☐ Walk/Drive by ☐ Internet ☐ Other ___________________

How would you like to receive courtesy appointment reminders? ☐ E-mail ☐ Phone Call: Cell or Home ☐ Decline reminder

Primary Care Provider ______________________________ Referring Provider (if different) __________________________

Next appointment with Primary Care or Referring Provider (if applicable) ____

Medical Diagnosis or Primary Concern ____

Approximate Date of Onset ___________________________________ Date of Surgery ______________________________

Are you currently or have you received Home Health services this year? ☐ YES ☐ NO **Discharge Date** ____ /____ /_____

Is the pain or injury listed above related to a motor vehicle accident or an accident at work? ☐ YES ☐ NO

If yes, choose one: ☐ MOTOR VEHICLE ACCIDENT ☐ WORKPLACE ACCIDENT Date of Accident ____ /____ /_____

INSURANCE/GUARANTOR INFORMATION

Primary Insurance _______________________________________ Policy/Group # __________________________________

Policy Holder Name ____ Date of Birth _________________________

Relationship to Patient ____ Policy Holder SS# _________________________

Secondary Insurance ______________________________________ Policy/Group # __________________________________

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 of Patient (or Legal Guardian) Date

SCHEDULING AND CANCELLATION POLICY

- When cancelling a scheduled appointment, we require patients notify our office by phone **48 BUSINESS HOURS** prior to the scheduled appointment time. If you cancel an appointment within **48 BUSINESS HOURS** prior to the scheduled appointment time there is an automatic CANCELLATION FEE applied to the patient account.
- The charge for a LATE CANCELLATION OR NO-SHOW FEE is $**40.00** **per hour** of scheduled appointment time.
- There is no charge for cancelling an appointment due to illness prior to the scheduled appointment time.

____ _________________________________

Signature of Patient (or Legal Guardian) Date

NEXT PAGE (over) ➡

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. Past due balances greater than 90 days old will be charged a late fee up to $15. 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 of Patient (or Legal Guardian) 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 operations 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 of Patient (or Legal Guardian) Date

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.

Photographs and/or videos taken will **NOT** be used 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/patient for the purpose of customization of patient care and use as indicated by me above.

______________________________ ______________________________

Signature of Patient (or Legal Guardian) Date

ADVANCE PHYSICAL THERAPY

CERTIFIED POSTURAL RESTORATION CENTER

77 South Elliott Road, Chapel Hill, NC 27514 phone 919.932.7266 fax 919.932.7250

CONSENT FOR EMAIL COMMUNICATIONS

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).

☐ I do not give consent to use email for any purpose. ☐ I do not wish to receive updates about special clinic events.

____ ______________________________

Signature of Patient (or Legal Guardian) Date

CONSENT FOR ELECTRONIC INVOICES AND/OR STATEMENTS

☐ YES, please send all invoices and account statements by EMAIL.

☐ DECLINE, I prefer to receive invoices and account statements by postal mail.

By opting for electronic invoicing, patients grant Advance Physical Therapy permission to send invoices for account balance(s) as well as current and past account statements by electronic delivery to the designated e-mail address specified below. Examples of electronic invoicing include but are not limited to: documentation required by health savings and/or reimbursement accounts, payment receipts, current account balance, outstanding balance due. To receive e-Statements and electronic disclosures, you must have a working connection to the internet and a valid e-mail address. Access to a printer or the ability to download and electronically store copies of your statements is strongly recommended, but not required. By accepting these Terms and Conditions, you are confirming that you have access to a computer and/or printer which satisfies these requirements. Please read the following Authorization and Consent disclosure before accepting and agreeing to this disclaimer. A copy of this authorization will be provided to you by request only.

Payments can be made by cash/check/credit card in person, by check via postal mail, or credit card by phone.

By signing below you agree to inform our office of any **changes** in your **telephone number, mailing address, or designated e-mail address**. Notification of the changes listed above can be made by telephone call or written notice by postal mail.

1. By **telephone**: 919.932.7266
2. Written notice by **postal mail**: Advance Physical Therapy, 77 S. Elliott Rd., Chapel Hill, NC 27514.

You will receive an electronic invoice when a balance is due for your account.
Payment is **due upon receipt** of your electronic invoice.

I hereby give permission to the practitioner/s of Advance Physical Therapy, to deliver account invoices and/or requested statements by e-mail to the designated e-mail address specified below. I understand that Advance Physical Therapy cannot guarantee the security of Protected Health Information (PHI) via e-mail. Your information will not be intentionally distributed to any outside parties.

Designated e-mail ____ ☐ Use same email as listed above

____ ______________________________

Signature of Patient (or Legal Guardian) Date

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ADVANCE PHYSICAL THERAPY

ALLERGIES & CURRENT MEDICATIONS

ALLERGIES (choose one)

☐ NO KNOWN ALLERGIES ☐ MEDICATION ALLERGIES ______________________________

☐ LATEX ALLERGY ____

CURRENT HEIGHT ______ ft. ______ in. **CURRENT WEIGHT** ________ lbs.

☐ I am not currently taking any prescription medications, supplements, or over-the-counter medications.

1. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
2. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
3. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
4. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
5. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
6. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
7. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
8. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
9. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
10. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
11. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________
12. Medication ____________________________
   Frequency _____________________________
   Dosage _____________ Route _____________

☐ Patient brought medication list

☐ Medication list received from referring provider

Patient Name ____ Date ___________________________

MEDICAL HISTORY INTAKE FORM

Have you or an immediate family member ever been told you have any of 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*
Cirrhosis/Liver Disease	*Chemical Dependency (Drugs/Alcohol)*	*Depression*
Diabetes	*Eating Disorder (Anorexia, Bulimia)*	*Headaches*
Heart Attack	*Hemophilia or slow healing*	*High Blood Pressure*
High Cholesterol	*Kidney Disease/Stones*	*Multiple Sclerosis*
Osteoporosis	*Scoliosis*	*Stroke*
Tuberculosis	*Other (please describe)* ________________________________	

HAVE YOU EVER HAD (please check any that apply)

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

FOR WOMEN (please circle)	Are you pregnant? **Y / N**	**FOR MEN** (please circle)
Endometriosis	# of pregnancies? ______	Prostate Problems
Pelvic Inflammatory Disease	# of live births? ______	Genital Pain / Problems

GENERAL HEALTH

1. I would rate my health as: ***Excellent*** ***Good*** ***Fair*** ***Poor***
2. Have you been sick in the last 3 weeks? **YES / NO** if YES, describe ______________________________
3. Have you noticed any lumps or thick skin/muscle anywhere on your body? _________________________
4. Do you have any sores that have not healed or any change in size, shape, or color of a wart or mole? **YES / NO** (circle one) if YES, describe ____
5. How many alcoholic drinks do you consume per week?____
6. How much caffeine do you consume daily (soda, coffee, tea, chocolate)?___________________________
7. Do you smoke or chew tobacco? **YES / NO** How much per day?________________ # of years?_______
8. I **used** to smoke/chew tobacco but quit. How much per day?________________ # of years?_______
9. I would like to quit smoking/chewing tobacco? ☐ **YES** ☐ **NO**
10. Are you on any special diet?____
11. Do you currently exercise? **Y / N** (circle one) If yes, how often? __________________________________

    If yes, what type(s)? ____

NEXT PAGE (over) ➡

Patient Name ____ Date ___________________________

12. How many falls have you had in the past year? ____

13. Describe problems with your balance or fear of falling? _______________________________________

____

14. 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 recently?
☐ **NO** ☐ **YES**, what? ______________________________________ When? ______________________
Results ____

3. Have you had any lab work done recently? ☐ **NO** ☐ **YES**, Results: ____________________________

4. Please describe any other recent clinical tests ____

5. Please list other providers or treatments for this condition ______________________________________

6. Please list any significant operations that you have had and date _________________________________

____

____

____

7. 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? ☐ **YES** ☐ **NO**, ____

A. Notifier: ADVANCE PHYSICAL THERAPY

B. Patient Name ________________________ **C. Identification Number** ____________________

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. "PT by telehealth may not be deemed medically necessary by Medicare"**, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for **D. "PT by telehealth may not be deemed medically necessary by Medicare"**.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy by telehealth may not be deemed medically necessary by Medicare	Medicare will only pay for services deemed medically necessary.	$25 per 15 minutes

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option listed below in section G, about whether to receive **D. "Physical Therapy by telehealth may not be deemed medically necessary by Medicare**."

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want **D. "Physical therapy by telehealth may not be deemed medically necessary by Medicare"**. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but ***I can appeal to Medicare*** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. "Physical therapy by telehealth may not be deemed medically necessary by Medicare** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. ***I cannot appeal if Medicare is not billed***.

☐ **OPTION 3.** I don't want the **D. "Physical therapy by telehealth may not be deemed medically necessary by Medicare"** listed above. I understand with this choice I am **not** responsible for payment, and ***I cannot appeal to see if Medicare would pay.***

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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