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 _____ Profession _____

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? ☐ NO ☐ YES, **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 ☐ BILL INSURANCE POLICY ☐ SELF-PAY

Primary Insurance _____ Policy # _____

Policy Holder Name _____ Date of Birth _____ Group # _____

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

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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
CERTIFIED POSTURAL RESTORATION CENTER
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NON-COVERED SERVICES WAIVER

This form applies to all patients covered by private insurance

Your insurance company reserves the right to decide what services are medically necessary for you and which health related services they will cover. Services which are acceptable to your insurance company are labeled "covered benefits." Services which they will not cover are labeled as "non-covered services."

Advance Physical Therapy offers treatment options which may not be covered by your insurance company. For example, intensive therapy programs are offered to patients who travel long distances for specific techniques which are not available to them locally. The intent is to offset travel time with increased treatment time per day to minimize the need for frequent, long travel. Another example is treatments which address complex problems. Patient education, as well as training in new postures and movement patterns may require longer than usual sessions to most efficiently achieve desired results.

If your insurance company denies coverage of longer sessions, labeling them as "non-covered services" or "medically not necessary" you have the option to self-pay for these additional services, if you wish.

Discounted Self-Pay Rate
Initial evaluation hour: $180.00 Hourly rate: $120.00

I acknowledge that I have been informed in advance of receiving services, that these services may not be covered by my health insurance plan. I have chosen to receive these services, and understand that I will be financially responsible for the services not covered by my health insurance plan, which will be billed at the rates listed above.

☐ DECLINE NON – COVERED SERVICES

_____

Patient Name

_____ _____

Signature of Patient (or Legal Guardian) Date

*This form must be signed by the patient or legal guardian **PRIOR** to all appointments scheduled for more than sixty (60) minutes, receiving any non-covered services or items, and must be maintained in the patient's medical record.*

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 <u>YOU</u> 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*

ALLERGIES

☐ NO KNOWN ALLERGIES ☐ LATEX ALLERGY

☐ MEDICATION ALLERGIES _____

<u>FOR WOMEN</u> (please circle)	Are you pregnant? **Y / N**	**<u>FOR MEN</u>** (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. Please list all prescription medications _____
   _____
3. Please list all over-the-counter medications _____
4. Please list all vitamins/supplements _____
5. Have you been sick in the last 3 weeks? **YES / NO** 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?
   YES / NO (circle one) if YES, describe _____
8. How many alcoholic drinks do you consume per week? _____
9. How much caffeine do you consume daily (soda, coffee, tea, chocolate)? _____

NEXT PAGE (over) ➡

Patient Name _____ Date _____

10. Do you smoke or chew tobacco? ☐ **NO** ☐ **YES**, How much per day? _____ # of years? _____

11. I used to smoke/chew tobacco but quit. How much per day?_____# of years? _____

12. I would like to quit smoking/chewing tobacco? ☐ **YES** ☐ **NO**

13. Are you on any special diet? _____

14. Do you currently exercise? ☐ **NO** ☐ **YES**, how often? _____

Types of exercise_____

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*
_____ *Urinary issues/Stress incontinence*
_____ *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 the dates _____

_____

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**, _____

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NON-COVERED SERVICES WAIVER FOR TELEHEALTH

This form applies to all patients covered by private insurance

Your insurance company reserves the right to decide what services are medically necessary for you and which health related services they will cover. Services which are acceptable to your insurance company are labeled "covered benefits." Services which they will not cover are labeled as "non-covered services."

Advance Physical Therapy is now offering telehealth treatment options which may not be covered by your insurance company. For example, physical therapists can connect with patients through an online platform to deliver patient education, create or review care plans, and ensure patient success in performance of therapeutic exercises.

If your insurance company denies coverage of telehealth sessions, labeling them as "non-covered services" or "medically not necessary" you have the option to self-pay for this service, if you wish.

TELEHEALTH RATES:

Telehealth Treatment Rate (for existing and new patients): $25 per 15 minutes
New Patient Telehealth Initial Encounter: $150 for 1 hour
New Patient Telehealth Screening: $75.00 for 30 minutes

I acknowledge that I have been informed in advance of receiving telehealth services, that these services may not be covered by my health insurance plan. I have chosen to receive these services, and understand that I will be financially responsible for the services not covered by my health insurance plan, which will be billed at the rates listed above.

_____

Patient Name

_____ _____

Signature of Patient (or Legal Guardian) Date

*This form must be signed by the patient or legal guardian **PRIOR** to patient receiving any non-covered service(s) or item(s), and must be maintained in the patient's medical record.*