



ADVANCE PHYSICAL THERAPY

CERTIFIED POSTURAL RESTORATION CENTER

PEDIATRIC Patient Information

First Name _____ MI _____ Last _____ Preferred Name _____

Date of Birth ____/____/____ Age _____ Gender _____ Pronouns _____

Mailing Address _____ City _____ State ____ Zip _____

Primary Contact Name _____ Relationship to patient _____ Phone _____ Home/Cell _____

Alternate Contact Name _____ Relationship to patient _____ Phone _____ Home/Cell _____

Email _____ Legal Guardian SS# _____

Grade in School _____ OR Year in College _____ School attending _____

How did you hear about APT? _____

Would you like to receive courtesy appointment reminders? E-mail Phone Call: _____ 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 _____

Is the pain or injury listed above related to a motor vehicle accident? YES NO **Date of Accident** ____/____/____

INSURANCE/GUARANTOR INFORMATION

Primary Insurance _____ Member ID # _____ Group # _____

Responsible Party Name _____ Date of Birth _____ SS# _____

Secondary Insurance _____ Member ID # _____ 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, including teletherapy. If patient is a minor, a parent or legal guardian must sign. **Consent must be signed before we begin treatment.**

Signature of Patient (or Legal Guardian) _____
Date

CONSENT FOR USE AND DISCLOSURE 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

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, NC.

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

NON-COVERED SERVICES WAIVER DOES NOT APPLY FOR MEDICAID OR SELF-PAY

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.

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 below.

DISCOUNTED SELF-PAY RATE Initial evaluation hour: \$200.00 Hourly rate: \$140.00

Approve Non-Covered Services

Decline Non-Covered Services

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, including but not limited to, appointment reminders, account statements/invoices, and communication with PT's/staff. 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. Use the same email listed
- I do not give consent to use email for any purpose. I do not wish to receive updates about special clinic events.

Designated e-mail (if different) _____

Signature of Patient (or Legal Guardian)

Date

SCHEDULING AND CANCELLATION POLICY

- When cancelling a scheduled appointment, we require patients to 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, an automatic LATE CANCELLATION FEE is 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.
- We understand there are times when you must miss an appointment due to emergencies or illness. To ensure optimal patient care, upon 3 consecutive cancelled or no-show appointments, Advance Physical Therapy may discharge the current episode of care.

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 and/or recorded will NOT be used for any purpose other than patient treatment unless authorized by the signee via a separate photo and/or video 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

NEXT PAGE (over) →

Patient Name _____ Date _____

MEDICAL HISTORY INTAKE FORM

FAMILY HISTORY (please check and indicate relation) i.e. "self", "mother", "brother", etc.

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Angina or chest pain | <input type="checkbox"/> Anxiety/Panic attacks |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma or other breathing problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cirrhosis/Liver Disease | <input type="checkbox"/> Drug or Alcohol problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating Disorder (Anorexia, Bulimia) | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hemophilia or slow healing | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other (please describe) _____ | |

Has the patient been diagnosed with (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Autism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> COVID-19 | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Headaches / Concussion |
| <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Prematurity: # of weeks _____ | <input type="checkbox"/> Reflux / Constipation |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> |
| <input type="checkbox"/> Braces on your teeth, other significant dental work or tooth extractions _____ | | |
| <input type="checkbox"/> Genetic Disease _____ | | |
| <input type="checkbox"/> Growth Concerns _____ | | |
| <input type="checkbox"/> Other (please describe) _____ | | |

PATIENT ALLERGIES

NO KNOWN ALLERGIES

LATEX ALLERGY

MEDICATION OR FOOD ALLERGIES _____

GENERAL HEALTH

- I would rate the patient's health as: **Excellent** **Good** **Fair** **Poor**
- Please list all prescription medications _____
- Please list all over-the-counter medications _____
- Please list all vitamins/supplements _____
- Has the patient been sick in the last 3 weeks? **NO** **YES**, describe _____
- Have you noticed any lumps or thick skin/muscle anywhere on patient's body? _____
- Are there any sores that have not healed or any change in size, shape, or color of a wart or mole?
 NO **YES**, describe _____
- How much caffeine does patient consume daily? (soda, coffee, tea, chocolate) _____

NEXT PAGE (over) →

DEVELOPMENTAL MILESTONES

1. Age the patient sat independently _____ months Crawled independently _____ months
 Stood independently _____ months Walked independently _____ months
2. Age of first words _____ months Do you have concerns about child's speech: **YES** **NO**
3. Are patient's fine motor skills appropriate for age? _____
4. Does the patient have any sensory processing issues? (i.e. aversion to light, sound/noises, tags in clothes, the way things feel-carpet, being messy, difficulty sitting/standing still, visual concerns, etc.) **DESCRIBE**

RECENT MEDICAL / SURGICAL HISTORY

1. Has the patient recently had any of these problems? (*please check all that apply*)
 - Blood in urine, stool, vomit or mucous*
 - Fever, chills, day or night sweats*
 - Changes in bowel and/or bladder function*
 - Skin rash or changes*
 - Leaking urine*
 - Clumsiness, tripping, falling*
 - Swelling or lumps anywhere*
 - Unusual fatigue or drowsiness*
 - Memory loss*
 - Sudden weakness*
 - Jaw pain, noise, teeth grinding*
 - Dizziness, fainting, or blackouts*
 - Nausea, vomiting, loss of appetite*
 - Throbbing sensation in belly or elsewhere*
 - Cough*
 - Heart Palpitations*
 - Numbness or tingling*
 - Problems seeing and/or hearing*
 - Difficulty swallowing or speaking*
 - Confusion*
 - Trouble sleeping*
 - Other* _____
2. Has the patient ever been treated with chemotherapy, or radiation therapy? _____
3. Has the patient had any X-rays, CT scans, MRI, bone scans or other imaging tests done recently?
 NO **YES** If yes, when? _____ Results? _____
4. Has the patient had any lab work done recently? **NO** **YES** If yes, results _____
5. Please describe any other recent clinical tests _____
6. Please list other providers or treatments for this condition _____
7. Has the patient received (-ing) OT or ST? _____
8. Is the patient receiving school-based PT or other PT? _____
9. Please list any significant surgery the patient has had and the date _____

LIVING ENVIRONMENT

1. The patient lives at home with _____
2. Are there stairs at home? **YES** **NO** Is there a safety concern on stairs? **YES** **NO**
Please indicate below anything else you would like to discuss with the pediatric physical therapist

