Advanced Physical Therapy, LLC

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ SSN _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

NAME: _____ DATE: _____

REFERRING PHYSICIAN: _____ DATE OF BIRTH: _____

FAMILY PHYSICIAN: _____

MEDICAL HISTORY

Is your current condition related to an injury? **Yes___** **No___**

If YES, was the injury related to: **Auto___** **Work___** **Other___** **Date of Injury** _____

Are there any lawsuits pending regarding your condition? **Yes___** **No___**

Have you received physical/speech therapy in the last year? **Yes___** **No___**

If YES, refer to your insurance policy for limitations.

Please check any of the following conditions you have or may have had in the past:

_____ Heart Disease	_____ Tuberculosis	_____ Asthma
_____ High Blood Pressure	_____ Currently Pregnant	_____ Stroke
_____ Heart Murmur	_____ Fatique/Energy Loss	_____ C.O.P.D.
_____ Mood Disorders	_____ Chest Pain/Discomfort	_____ Hepatitis
_____ Shortness of Breath	_____ Ankle Swelling	_____ Anemia
_____ Kidney Disease	_____ Epilepsy/Seizures	_____ Diabetes
_____ Dizzy Spells	_____ Allergies	_____ Hernia
_____ Headaches	_____ Cancer: Type_____	
_____ Loss of Bladder/Bowel Control	_____ Other: _____	

ORTHOPEDIC LIMITATIONS

Please check any of the following conditions that you have or have had in the past:

_____ Osteoporosis	_____ Scoliosis
_____ Broken Bones	_____ Sprains/Strains
_____ Arthritis	_____ Balance/Walking Problems
_____ Fibromyalgia	_____ Limited Range of Motion
_____ Slipped/Ruptured Disc	_____ Subluxed/Dislocated Joints
_____ Weakness	_____ Painful Grinding/Cracking in a Joint
_____ Compression Fractures	

Have you had a recent: X-Ray___ MRI___ CT Scan___

If so, when? _____ _____ _____

Please list hospitalizations or surgeries you have had in the last five years, including dates:

_____

_____

Please list any medications you are currently taking:

_____

Are you allergic to any medications: Yes___ No___ If yes, please list: _____

Signature: _____ Date: _____

PT Signature: _____ Date: _____

MEDICARE QUESTIONNAIRE

Patient Name: _____ Date: _____

Social Security Number: _____

	(Circle One)	
1. Is this illness/injury covered by Workers' Compensation? If yes, note employer or insurer's name and address and claim number in #10.	Yes	No
2. Is this illness/injury covered under the Black Lung Program?	Yes	No
3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)?	Yes	No
If yes, do you want the DVA to be contacted for authorization of these services?	Yes	No
4. Is this illness/injury the result of an auto accident? If yes, enter the responsible auto insurance/insured in #10.	Yes	No
5. Is another party's liability insurance responsible for this illness/injury? If yes, enter the responsible party's insurance in #10.	Yes	No
6. Are you covered by an Employer Group Health Plan (EGHP), including Federal Employee Health Benefits? If yes, enter the EGHP data in #10.	Yes	No
7. Are you or your spouse actively employed by an establishment of 20 or more employees? If yes, enter the EGHP data in #10.	Yes	No
8. Are you under age 65 and entitled to Medicare due to a disability? If no, move to #9.	Yes	No
If yes, are you or your spouse actively employed by an establishment of 100 or more employees (LGHP - Large Group Health Plan)? If yes, enter the LGHP data in #10	Yes	No
9. Are you entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)?	Yes	No
If yes, have you completed the ESRD coordination period? If no, enter the EGHP data in #10.	Yes	No
Complete the following information only if you answered "Yes" to one or more of questions 1-8, or "No" to answer 9b.		
10. Name of Insurance Company:		
Insured's Name and Policy Number:		
Employer:		
Insurer's Address:		
Claim Number:		

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USE AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE IS POSTED ON THE FRONT DESK IN OUR OFFICE.

PLEASE REVIEW IT CAREFULLY

Advanced Physical Therapy, LLC is committed to maintaining and protecting the confidentiality of our patients' medical, personal, and sensitive information. We are required by federal and state law to protect the privacy of your individual identifiable health information and other personal information and send you this Notice about our policies, safeguards, and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notices, if we revise it.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan or from other sources of coverage such an automobile insurer, or worker's compensation carrier. For example, your insurer may request and receive information on dates of service, the type of services provided, and the medical condition being treated.

Health Care Operation: Your health information may be used as necessary to support the day-to-day activities and management of **Advanced Physical Therapy, LLC.**

For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Lawsuits and Disputes: Your health information may be disclosed in response to a court or administrative order. For example, if you are involved in a lawsuit or dispute and **Advanced Physical Therapy, LLC** is served with a subpoena, warrant, summons, or other lawful process this office may be required by law to disclose your health information.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state Public Health Department.

Information About Treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Appointment Reminders: Your health information may be used by our staff to contact you regarding appointment openings and reminders. If you have any concerns about us leaving messages or information pertaining to appointment dates and times with other household members, please let us know. No confidential patient information will be left by phone.

Other uses and Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific authorization. If you change your mind after authorizing a use or disclosure of your information you may submit in written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified **Advanced Physical Therapy, LLC.**

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:

- ☐ The right to request restrictions on the use and disclosure of your protected health information.
- ☐ The right to receive confidential communications concerning your medical condition and treatment
- ☐ The right to inspect and copy your protected health information
- ☐ The right to amend and submit corrections to your protected health information
- ☐ The right to receive an accounting of how and to whom your protected health information has been disclosed
- ☐ The right to receive a printed copy of this notice.

Rights to Revise Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policy and practices may be required by changes in federal and/or state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information:
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing to our office.

Complaints:
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter discussing your concerns to:

Advanced Physical Therapy, LLC
Attn: Office Manager
6399 Goodman Road, Suite 108
Olive Branch, MS 38654
(662)-892-8339

If you feel that your privacy rights have been violated, you may file a complaint with our office or the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

I ACKNOWLEDGE that I have received a copy of Advanced Physical Therapy LLC's notice of privacy practices. I understand that this information describes how Advanced Physical Therapy LLC may disclose and use my protected health information:

Patient's Name: _____ (please print)

Patient's Signature: _____

Date: _____
This Notice is effective on or after April 15, 2003

Advanced Physical Therapy, LLC

Financial Policy

- Our practice accepts insurance from most insurance companies. As a courtesy, our practice will review your insurance coverage, estimate your insurance company payment, and file your claim with your insurance carrier.
- Your insurance coverage is a contract between you and your insurance carrier; however, we will assist you to maximize your insurance benefits.
- If your insurance does not remit payment within 60 days, the balance will be due in full from you.
- If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problems.
- Returned checks and balances greater than 30 days may be subject to additional fees and interest charges of 1.5% per month. You will be responsible for any charges incurred due to collection proceedings, attorney's fees or court costs.
- Any money paid to you by your insurance company for services billed and rendered by Advanced Physical Therapy, LLC or any of its associates shall be paid to Advanced Physical Therapy, LLC immediately upon receipt. Failure to do so is illegal.
- You are responsible for any portion of your bill which is denied or not paid by your insurance carrier. This includes, but is not limited to, deductible, coinsurance and co-payments.
- I authorize payment of medical benefits from my insurance to Advanced Physical Therapy, LLC and the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents.
- I understand that I am responsible for all charges including those not covered by insurance. I understand my responsibilities as outlined in the Financial Policy.

Signature_____ Date_____

Advanced Physical Therapy, LLC Appointment Cancellation Policy

There is a $25 charge for missed or cancelled appointments without 24 hours notice.

(exceptions will be made for emergencies)

- We have reserved an allotted time for you which is now lost.
- We are unable to bill your insurance for this amount.
- If you have more than three "no shows" you will be discharged from therapy. We want you to get the maximum results from therapy and this means attending therapy on a regular basis.
- Please be sure that you have given us an active/valid phone number so that we can reach you.

Signature_____ Date_____