

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 _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	Date of Birth _____
	Colnsurance _____	

Secondary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	Date of Birth _____
	Colnsurance _____	

Tertiary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	Date of Birth _____
	Colnsurance _____	

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: _____
REFERRING PHYSICIAN: _____
FAMILY PHYSICIAN: _____

DATE: _____
DATE OF BIRTH: _____

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 | ___ Fatigue/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: _____
PT Signature: _____

Date: _____
Date: _____

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 _____