ADVANCED PHYSICAL THERAPY & HEALTH SERVICES
MEDICAL HISTORY INTAKE FORM

Name: _____ Age: _____ Today's date: _____

Occupation & work tasks / duties: _____

State your current problem: _____

Date of injury / start of pain:_____ Did this occur at work? _____ Are you working now? _____

How did the pain or injury occur? _____

Have you had this pain/injury before? _____ When? _____ For how long? _____

What treatment did you have for it? _____

Medication you are taking for this pain/injury: _____

Other medications you are taking (or attach a list): _____

_____

What sports/recreational activities do you participate in? _____

_____

Do you: Smoke _____ # of cigarettes/day _____ Drink alcohol _____ How often? _____

What is/are your goal(s) for physical therapy? _____

Please indicate the following conditions/diseases you have or have had in the past.

☐ Heart condition	☐ Pacemaker	☐ High blood pressure/Hypertension
☐ Cancer/Tumor	☐ Tuberculosis	☐ Epilepsy/Seizure Disorder
☐ HIV / AIDS	☐ Asthma	☐ Allergies
☐ Diabetes	☐ Impaired sensation	☐ Impaired hearing / vision
☐ Metal / plastic implants	☐ Childhood Disease (e.g. Polio)	☐ High cholesterol
☐ Stroke	☐ Am or could be pregnant	☐ Other _____

Please explain any of the above (dates & description): _____

_____

_____

_____

Please list any surgeries (dates & description): _____

_____

_____

Other: _____

_____

Patient's signature: _____ *Chart #:* _____

Therapist's signature: _____

ADVANCED PHYSICAL THERAPY & HEALTH SERVICES
PATIENT INFORMATION FORM

Patient Name (Last - First - Middle initial):

_____

Address _____

_____

Home Phone: (_____) _____-_____ Date of Birth _____/_____/_____Sex: _____

Work Phone: (_____) _____-_____ Cell phone: (_____) _____-_____

Email: _____

Social Security Number: _____-_____-_____

Driver's License Number: _____

Employer Name: _____

Employer's Address: _____

_____

Employer's Phone #: _____ Contact: _____

Who is financially responsible for this bill (name & relation)? _____

_____

Who is your current Home Health Agency? _____

In case of emergency, contact: _____

Phone #: (_____) _____-_____ Relationship _____

Federal Compliance of Confidentiality

Please read the following statements and answer accordingly:

- I agree, that by allowing the staff of Advanced Physical Therapy and Health Services to copy my insurance cards, that I willingly assign benefits to be paid directly to the therapist treating me.

  Yes_____ No_____

- I agree, as a patient of Advanced Physical Therapy and Health Services, any co-pays, deductibles and benefits that are deemed "not covered" by my insurance company, are my responsibility and agree to pay my part of any charge left unpaid. This includes denials by Worker's Compensation carriers, record copy fees etc.

  Yes_____ No_____

- I give the doctor/staff of Advanced Physical Therapy and Health Services the authorization to call my home or work number provided on my demographic sheet to notify me of upcoming appointments, test results, or billing issues.

  Yes_____ No_____

- I authorize Advanced Physical Therapy and Health Services to submit all my claims on behalf of the therapists and doctors. I agree that Advanced Physical Therapy and Health Services may contact me at my home or work numbers provided regarding any billing issues or questions that they may have on behalf of the doctors.

  Yes_____ No_____

- I authorize the release of any medical records pertaining to my medical condition that will assist in the continued treatment of my care to Advanced Physical Therapy and Health Services. This includes but is not limited to any hospital, MRI/CT center, primary care physician, specialist, physical/occupational therapy department/provider or any other center that I have had medical treatment with or will have as a result of my treatment.

  Yes_____ No_____

- Have you ever received home health services?

  Yes_____ No_____

- Are you currently receiving any type of home health service?

  Yes_____ No_____

  If you are in a current episode of *any* home health service, your insurance will *not* cover outpatient physical therapy. You will be responsible for your bill.

  Please initial _____

_____ _____

(Patient/Guardian Signature) (Date)

ADVANCED PHYSICAL THERAPY & HEALTH SERVICES
ATTENDANCE, TARDINESS, BILLING & TREATMENT POLICIES

- If you need to cancel an appointment, please call 24 hours in advance. Our policy is to charge $35.00 for missed appointments or if they are not cancelled properly. Please help us serve you better by keeping scheduled appointments.

- The Patient and/or Responsible Party agrees to pay balance due within 30 days of the date of the first invoice. After 30 days the balance will incur late payment interest at the rate 1.5% per month. In the event that a balance remains unpaid for more than 90 days, the medical provider may refer the account to a third party agency or attorney for collection and legal action. The patient shall be responsible for all collection costs and reasonable attorney's fees incurred in the collection of the account.

- If the patient fails to keep a third appointment, the physical therapist will inform the physician who prescribed the orders for physical therapy, and the patient will be discharged from treatment.

- It is important that the patients keep their scheduled appointments and show up on time. Treatment sessions will be canceled if the patient is more than 15 minutes late for their scheduled appointment. If you are going to be late, please call us to see if other arrangements can be made.

- No children are allowed in the treatment areas/rooms. If children must accompany the patient, a chaperon must be present with the child in the waiting room.

- Out of respect for other patients, please do not wear any perfumes or colognes to the physical therapy sessions.

- Patient confidentiality is a priority. Do not ask the therapists/staff about other patients in the clinic. We protect our patients' privacy, as well as yours.

Signature: _____

Date: _____