

**ADVANCED PHYSICAL THERAPY & HEALTH SERVICES**

**MEDICAL HISTORY INTAKE FORM**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Full Address: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_ BMI: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**REASON FOR TODAY'S VISIT**

[ ] New Complaint [ ] Reoccurring Complaint [ ] Chronic Complaint

Please rate the level of your symptoms / pain / disability:

**BEST - 0 1 2 3 4 5 6 7 8 9 10 - WORST**

Date of injury/start of symptoms: \_\_\_\_\_

How did symptoms begin? \_\_\_\_\_

Did this occur at work? Yes No

Are you currently working? Yes N

**Previous Medical History- Please check all that apply:**

- |  |   |
|--|---|
| <input type="checkbox"/> Heart Condition         | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Cancer/Tumor            | <input type="checkbox"/> High Cholesterol     |
| <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Epilepsy/Seizure     |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Metal/Plastic Implants  | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Impaired sensation      | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Impaired hearing/vision |   |
| <input type="checkbox"/> Osteoporosis/osteopenia |   |

History of smoking? Yes No  
If yes, how often? \_\_\_\_\_

FEMALES: Are you or could you be pregnant? Yes No

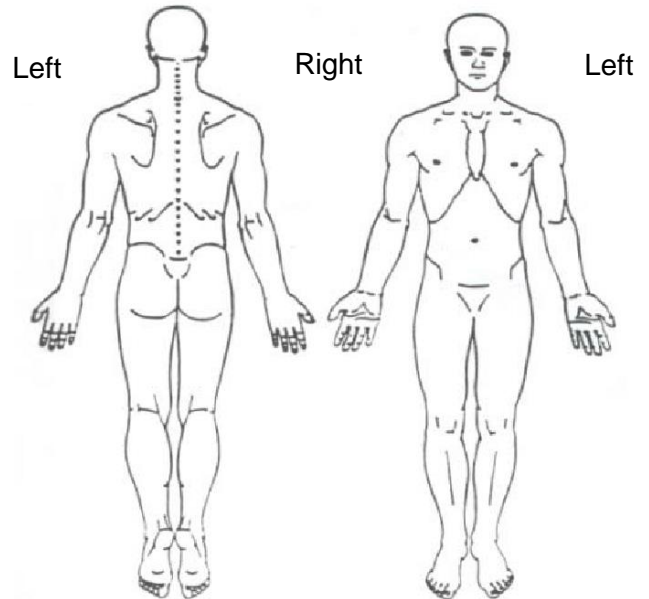
Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BODY DIAGRAM**

Please indicate below the location and type of symptoms you are experiencing:

- |                |                       |
|----------------|-----------------------|
| S – Sharp Pain | A – Aching, Dull Pain |
| N – Numbness   | T – Tingling          |
| B- Burning     | O – Other: _____      |



**WORK INFORMATION:**

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation/Title: \_\_\_\_\_

**PRIMARY PHYSICIAN:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**REFERRING PHYSICIAN (if different from above):**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION:**

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

Self-Pay (Cash/Credit/Check)

Patient's Medical Insurance

Workman's Compensation Insurance

Other: \_\_\_\_\_

Have you already had Physical Therapy (either here or at another facility) this year?  Yes  No

Are you currently receiving Home Health Services?  Yes  No

If applicable, who is your current Home Health Agency? \_\_\_\_\_

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* \_\_\_\_\_

**EMERGENCY CONTACT INFO:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Thank you for choosing Advanced Physical Therapy to be your provider!**

Please let us know who referred you to us:

Physician: \_\_\_\_\_

Friend: \_\_\_\_\_

Former/current Patient: \_\_\_\_\_

Internet Search

Advertisement

Social Media

Other: \_\_\_\_\_

**Advanced Physical Therapy & Health Services Policies**  
**& Federal Compliance of Confidentiality**

I understand that insurance coverage is not a guarantee of payment, and that I am ultimately responsible for services rendered at Advanced Physical Therapy & Health Services. I will honor Advanced Physical Therapy's payment and business policies as stated below:

- All co-payments and cash payments are due in full at the time of service.
- Co-insurance and deductibles are the patient's responsibility and will be invoiced once the patient's insurance provider provides the Explanation of Benefits (EOB). Invoices will be due 30 days after receipt.
- I authorize payment of benefits directly to Advanced Physical Therapy & Health Services for services provided.
- I agree, as a patient of Advanced Physical Therapy & 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., as well as if I have exhausted my yearly allotment of PT visits as regulated by my medical insurance.
- Advanced Physical Therapy & Health Services has the right to consult a collection agency if payment is past due 90 days. If any portion of the account balance exceeds 60 days the patient will be charged \$10 for each month the balance remains outstanding.
- I understand that I am financially responsible for payment of all services that are not paid by my insurance provider. Should my account be referred to collection, I will be responsible to pay costs of collections, including legal fees.
- I understand a fee of \$25.00 will be assessed for any check returned unpaid.
- I understand a fee of \$20.00 will be charged for medical records upon my request due to the time and cost of producing the copies.
- I give the staff/therapists of Advanced Physical Therapy and Health Services the authorization to call my cell, home, or work number provided on my demographic sheet to notify me of upcoming appointments, test results, or billing issues.
- I authorize Advanced Physical Therapy & 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.
- I authorize the release of any notes/medical records pertaining to my medical condition that will assist in the continued treatment of my care to Advanced Physical Therapy & Health Services. This includes referring physicians/primary care physicians, specialists, 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, as requested by the patient.

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(Patient/Guardian Signature)

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(Date)

**ADVANCED PHYSICAL THERAPY & HEALTH SERVICES**  
**ATTENDANCE, BILLING, & TREATMENT AREA POLICIES**

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**ATTENDANCE**

- **Late Appointments: \$30 Fee (if more than 10 minutes late to scheduled time)**
  - 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 more than 10 minutes late for your appointment, you will be charged a \$30 late fee. If you are going to be late, please call us to see if other arrangements can be made.
- **Missed Appointments or Same-Day Cancellations: \$100 Fee**
  - If you need to cancel an appointment, please call 24 hours in advance. Our policy is to charge \$100.00 for missed appointments or if they are not cancelled within 24 hours. Please help us serve you and others better by keeping scheduled appointments.
- If the patient misses or cancels three appointments in a row, the physical therapist may cancel future existing appointments. The patient may call to reschedule these appointments at another time.

**BILLING**

- The patient and/or responsible party agrees to pay balance due within 30 days of the date of the first invoice. After 60 days, the balance will incur a \$10.00 late fee per month that the balance remains outstanding. If 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.

**TREATMENT AREA POLICIES**

- For the safety of our patients, children are only allowed in the treatment area if they are the patient or if accompanied by an adult.
- Out of respect for other patients, please do not wear any perfumes/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: \_\_\_\_\_