Advanced Physical Therapy of Little Rock

Patient Information

Therapist: ____________________ Account Number: _________

Social Security #: _______________________________________ Sex: ____M ____F

Patient Name: (Last) ______________________________ (First) _________________________________ (MI) _______

Address: ______________________________ City: ______________________ State: _______ Zip: ______

Phone: Home ( )_________________________ Work: ( ) ____________________________

Cell: ( ) ________________________________ E-Mail Address: ____________________________

Date of Birth: _______________________ Marital Status ___M ___S ___D ___W

Patient Employer Name: _______________________________________

Occupation: ____

Emergency Contact Name: _______________________ Phone: ____________________________

Referring Physician: ____

Have you received physical therapy this year?_____Y_____N

Responsible Party Information* **(Name on insurance card)**

**If different than information above*

(Always "Self" for Medicare) (Always "Other" for Workman's Comp.)

Relation to Patient: ___Self ___Spouse ___Parent ___Other

Name: Last _______________________________ First ____________________________________ MI _______

Address: _______________________________City: ___________________State______ Zip______

Phone: Home ( )_____________________ Work: ( )___________________ Ext:_____

Date of Birth_______________________ SSN: ______-_____-_________ Sex: ____M ____F

Employer: ___________________________ Address: ______________________________________

City: ____ State: _________ Zip: __________________

Assignment of My Benefits

For PPO. POS, Med-Pay, PIP, Lien, and Private Third Party Payers.

I hereby instruct and direct ___________________________ insurance company to pay by check made out and mailed to:

Advanced Physical Therapy of Little Rock 10014 N. Rodney Parham Ste. 100 Little Rock, AR 72227

If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

*(Please read and **initial** each statement below and sign at the bottom)*

___ A photocopy of this Assignment shall be considered as effective and valid as the original.

___ I authorize the release of any medical or other information pertinent to my case to any insurance company adjuster.

___ I understand that I am financially responsible for all charges whether or not paid by insurance.

___ I understand that I am responsible to pay any co-pay and/or co-insurance at the time services are rendered and if I have an unmet deductible, I understand that I may be asked to make payments toward said deductible on each visit.

Dated this __________ day of ____________________________, 20____.

___________________________________ ____

Signature of Policyholder **Signature of Claimant, if other than Policyholder**

PLEASE PROVIDE INSURANCE CARD AND DRIVER'S LICENSE TO BE COPIED FOR OUR RECORDS

Informed Consent Agreement — *MUST* be completed prior to treatment.

I hereby indicate my wish to participate in the physical therapy treatment programs offered by Advanced Physical Therapy of Little Rock
I understand that the purpose of this program is to enhance my overall health and fitness.
I understand that dosed exercise may include aerobic conditioning, resistance training, and balance/proprioceptive training to provide cardiovascular conditioning, muscular strengthening, increased joint range of motion, and improved balance.
I understand that dosed exercise may challenge the muscle tissue, which can lead to a temporary and expected level or soreness.
I verify that my participation is fully voluntary and no coercion of any sort has been used to obtain my participation.
I have read the above information and I understand it fully and my questions concerning physical therapy procedures have been answered to my satisfaction.
I understand that I am free to deny answering any questions during the evaluation process or to withdraw from the program at any time.
I understand that the information that is obtained from this process is considered to be confidential and my respected health information is protected fully as outlined in the Statement of Privacy Notice presented to me.

____

Patient's Signature **Date**

____

APTC Representative Signature **Date**

Durable Medical Equipment

During the course of your treatment your therapist **may** issue you one or more items that **will not** be covered by your insurance. These items are known as "Durable Medical Equipment" or "DME." We ask that on the day you are issued any durable medical equipment that you stop by the front desk and pay for the item(s) or make payment arrangements if necessary.

Patient's Signature____________________________Date________________

Pelvic Floor Patients Only:

Your treatment will require the use of an internal electrode that will not be covered by your insurance. The cost of this equipment is a one-time charge of $50.00. We ask that you pay for this electrode in full by your exam date. If this is not possible, then please make payment arrangements with the front office on your first visit.

Temporary Orthotics	$20
Heel Lift	$12
Lymphedema Gloves	$22
Maternity SI Belt	$45
SI Belt	$38
Postural Support	$35
Slippery Stuff	$ 7
Biofreeze	$10
Lymphedema Sleeve	$75
Wrapping Kits	$100
Knee Stabilizer	$35
Stimtrode	$15
Custom Orthotics	$200
XLarge Ice Pack	$28
Cervical Ice Pack	$18
Stim Unit Rental (per month)	$45
Postpartum Support	$35

*This is not an inclusive list; other equipment may be issued based on individual needs.

Advanced Physical Therapy of Little Rock

Statement of Privacy Notice

Effective May 15, 2007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- ➢ You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- ➢ You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- ➢ You have the right to inspect and copy your health information.
- ➢ You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- ➢ You have a right to receive an accounting of disclosures of your protected health information made by us.
- ➢ You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (501) 224-5454. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (501) 224-5454. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Advanced Physical Therapy of Little Rock with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____

Patient's Name (print)

____

→ Patient's Signature Date

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows*" and late cancellations** inconvenience those individuals who need access to medical care. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments and provide the best care for all our patients.

We do not charge a fee for cancelled appointments but if it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. We understand that there may be times when you must miss an appointment due to an emergency or other obligation. However, when you do not call to cancel an appointment you may be preventing another patient from getting much-needed treatment.

In order for your treatment to be most effective, it is essential that you are consistently here on time for all your appointments. If you are running late, please call our office so we can make sure your therapist will still be able to treat you.

If you miss three appointments as a “no-show” or late cancellation, it will be necessary to discuss the discontinuation of your treatment until you can commit to keeping your scheduled appointments.

*A "no-show" is a patient who misses an appointment without calling to cancel. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

**A late cancellation is when a patient fails to cancel their scheduled appointment with a 24 hour notice.

How to Cancel Your Appointment

To cancel appointments, please call 501-224-5454. If you do not reach the office staff, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and offer you the next available appointment time.

I have read and understand the cancellation policy.

______________________________________ ________________

Signature Date

Name:________________________

Current Medication

Please list all medications you are currently taking.

1. Name of Medication:___________________________
   Dosage:____________________________________
   Frequency:__________________________________
   How do you take your medication? (Orally, injection, etc.)______
   ____
2. Name of Medication:___________________________
   Dosage:____________________________________
   Frequency:__________________________________
   How do you take your medication? (Orally, injection, etc.)______
   ____
3. Name of Medication:___________________________
   Dosage:____________________________________
   Frequency:__________________________________
   How do you take your medication? (Orally, injection, etc.)______
   ____
4. Name of Medication:___________________________
   Dosage:____________________________________
   Frequency:__________________________________
   How do you take your medication? (Orally, injection, etc.)______
   ____
5. Name of Medication:___________________________
   Dosage:____________________________________
   Frequency:__________________________________
   How do you take your medication? (Orally, injection, etc.)______
   ____
6. Name of Medication:___________________________
   Dosage:____________________________________
   Frequency:__________________________________
   How do you take your medication? (Orally, injection, etc.)______
   ____
7. Name of Medication:___________________________
   Dosage:____________________________________
   Frequency:__________________________________
   How do you take your medication? (Orally, injection, etc.)______

Advanced Physical Therapy of Little Rock **Patient Health Questionnaire**

10014 North Rodney Parham Suite 100 Little Rock, AR 72227 (501) 224-5454

Patient Name ______________________ *Date* ______________

1. *Describe your symptoms* ______________________

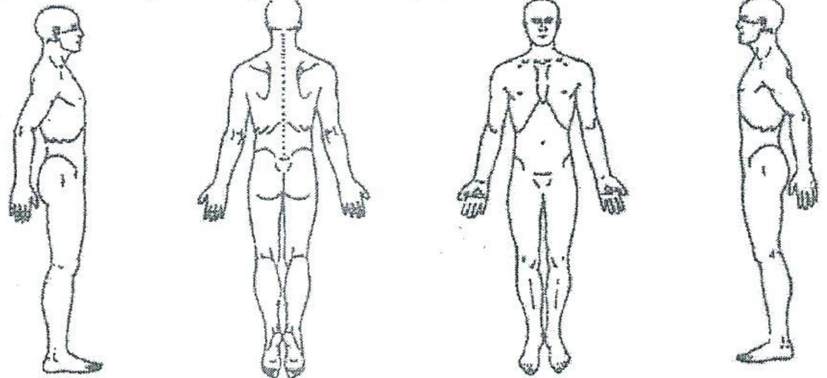
A. *When did your symptoms start?* ______________________

B. *How did your symptoms begin?* ______________________

Height: ______________ *Weight:* ______________

2. *How often do you experience your symptoms? Indicate where you have pain or other symptoms using "x".*

__ Constantly (76-100% of the day)
__ Frequently (51-75% of the day)
__ Occasionally (26-50% of the day)
__ Intermittently (0-25% of the day)



3. *What describes the nature of your symptoms?*

__ Sharp __ Shooting
__ Dull ache __ Burning
__ Numb __ Tingling

4. *How are your symptoms changing?*

__ Getting Better
__ Not Changing
__ Getting Worse

5. *During the past 4 weeks:*

A. Indicate the average intensity of your symptoms (circle one)

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

B. How much has pain interfered with your normal work (including both work outside the home and housework)?

__Not at all __ A little bit __Moderately __Quite a bit __Extremely

6. *During the past 4 weeks how much of the time has your condition interfered with your social activities?*

__ All of the time __ Most of the time __ Some of the time __ A little of the time __ None

7. *In general, would you say your overall health right now is.....*

__ Excellent __ Very Good __ Good __ Fair __ Poor

8. *Who have you seen for your symptoms?*

__ No one __ Medical Doctor __ Other
__ Chiropractor __ Physical Therapist

A. What treatment did you receive and when? ______________________

B. What tests have you had for your symptoms and when were they performed?

__ X-rays *date:* __________ CT Scan *date:* __________
__ MRI *date:* __________ Other *date:* __________

9. *Have you had similar symptoms in the past?* __ YES __ NO

A. If you have received treatments in the past for the same or similar symptoms, who did you see?

__ This Office __ Medical Doctor __ Other
__ Chiropractor __ Physical Therapist

10. *What is your occupation?*

____

__ Professional/Executive __ Laborer __ Retired
__ Secretarial __ Homemaker __ Other
__ Tradesperson __ FT Student

A. If you are not retired, a homemaker, or a Student, what is your current work status?

__ Full-time __ Self-employed __ Off work
__ Part-time __ Unemployed __ Other

Patient Signature ______________________ *Date* ______________