

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

Are you currently receiving home health? ___ 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 of 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	\$ 9
Biofreeze	\$10
Lymphedema Sleeve	\$75
Wrapping Kits	\$155
Knee Stabilizer	\$35
Stimtrode	\$15
Custom Orthotics	\$250
XLarge Ice Pack	\$28
Cervical Ice Pack	\$18
Stim Unit Rental (per month)	\$50
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.) _____

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Advanced Physical Therapy

10014 N. Rodney Parham #103 Little Rock AR 72227

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with the restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this constant.
- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

May we phone, e-mail or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

Information that may be disclosed? (circle all that apply): Medical Records Billing

If YES, please name the members allowed:

List any other individuals or organizations this information may be released to:

Information is being disclosed for the following purpose(s): _____

Unless otherwise revoked, this authorization will expire two (2) years from the dates this authorization is signed.

This consent was signed by: **(Please Print)** _____

Signature: _____ **Date:** _____

If Signed by legal representative, relationship to patient: _____ Date: _____

Witness: _____ Date: _____

*Advanced Physical Therapy
Patient History Questionnaire*

Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____

Describe the current symptoms that bring you to our clinic:

When did your symptoms first begin? Have they gotten worse or better since that time?

How has your quality of life been changed since your symptoms began?

What treatment have you had for your symptoms? (Check all that apply):

- Medication(s): _____ . Did this help? Y N
 Surgery: _____ . Did this help? Y N
 Physical Therapy: _____ . Did this help? Y N
 I have not had treatment for this problem.

GENERAL HEALTH

How many 8 oz glasses of water do you consume per day? _____

Please list all other fluids you consume, along with amount:

Current level of stress High Medium Low

Have you ever experienced physical, emotional, or sexual abuse? Yes No

Current psychiatric therapy Yes No

Do you engage in exercise? Yes No **If so, describe type and frequency:**

Please check all that apply regarding your medical history:

- Type II Diabetes Cardiovascular Disease Low back pain Chronic cough/COPD
 Auto-immune disease Other, please describe: _____

Please check all that apply regarding your surgical history:

- Back/spine Brain Bladder/female organs Bones/joints Abdominal organs Pacemaker/Defibrillator

Other, please describe:

URINARY HISTORY (Check all that apply):

Do you:

- Urinate more than once every 2 hours
- Have a sense of “urgency” to urinate
- Have difficulty initiating a urine stream
- Have a slow/intermittent stream of urine
- Have an odor associated with urine
- How many times per day do you urinate? ____
- Have painful urination
- Have Interstitial Cystitis
- Have chronic urinary tract infections
- Wake at night to urinate, if so how many times? ____
- Have difficulty emptying your bladder completely
- Leak urine with any of the following:
 - Sneezing
 - Laughing
 - Coughing
 - Lifting
 - Exercise
 - Sex
 - On the way to the bathroom
 - For no reason

BOWEL HISTORY (Check all that apply):

Do you:

- Have daily bowel movements
- Have constipation (< 3 bowel movements per week)
- Use laxatives regularly
- Consume daily fiber supplements
- Have pain during bowel movements
- Have Irritable Bowel Syndrome
- Strain to empty bowels
- Leak gas or feces

Number of bladder or bowel leakage episodes per day? Bowel _____ Bladder _____ N/A _____

On average, how much urine or stool do you leak? a few drops wets underwear wets outerwear wets the floor

What form of protection do you wear? Please note how many changes are required in 24 hours.

Tissue paper/thin liner _____ Maxi pad _____ Continence brief _____

OBSTETRIC/GYN HISTORY

Are you currently pregnant? If so, when is your due date? Yes _____ No

Date of last pap smear: _____ Date of last period: _____

Number of pregnancies: _____ Number of vaginal deliveries: _____ Number of Cesarean deliveries: _____

Number of difficult child births: _____ Number of episiotomies or vaginal tearing: _____

Please check all that apply:

- Menopause
- Painful periods
- Feeling that something is “falling out” of the pelvis
- Vaginal dryness/itching
- Pelvic or vulvar pain
- Problematic abdominal or Cesarean scar

Do you have a history of any of the following? (Check all that apply):

- Yeast infections
- Lichens Simplex
- Urinary tract infections
- Candida
- Lichens Sclerosis
- Eczema
- Genital Herpes or other STIs
- Recent change in vaginal discharge
- Contact dermatitis
- Psoriasis
- Other skin diagnoses: _____

CURRENT SEXUAL ACTIVITY

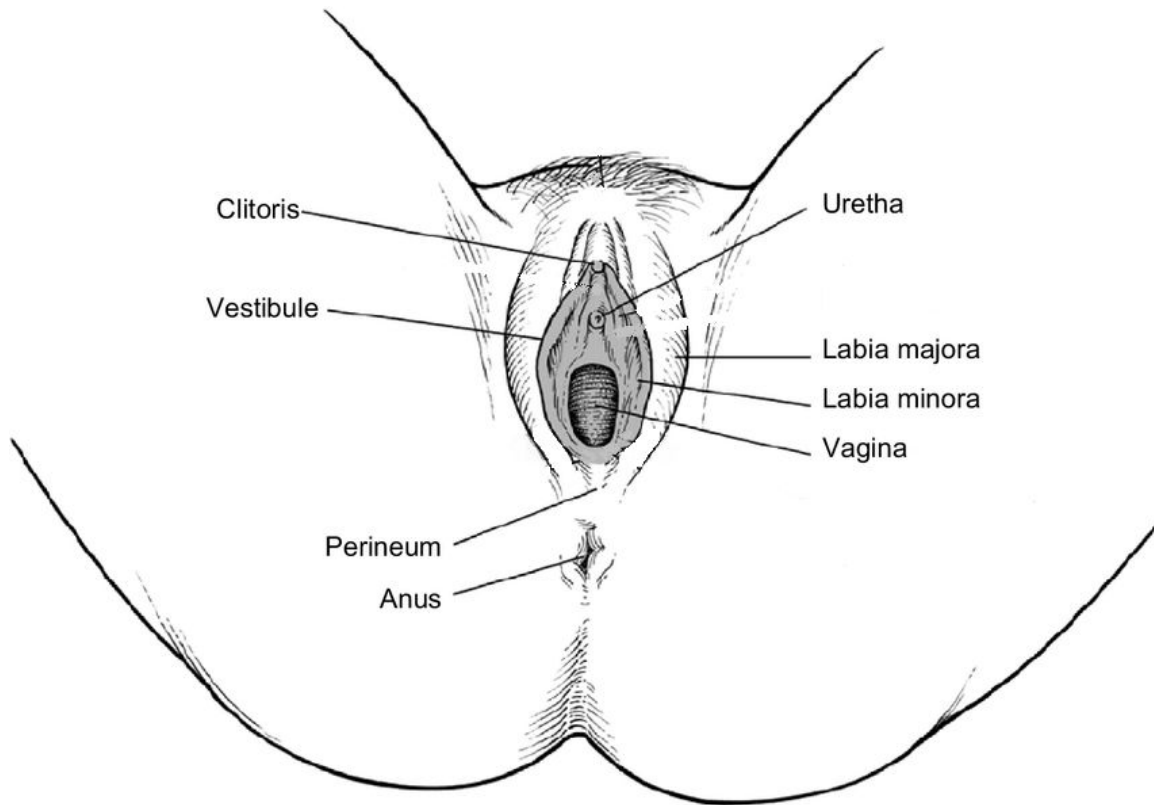
Sexually active Sexually inactive due to pain Sexually inactive due to other reasons

If you are sexually active, continue with this section (check all that apply):

Are you using a form of birth control? If so, please list the type and duration of use Yes No

-
- No pain with intercourse
 - No pain during intercourse, but will occur afterwards
 - Pain with intercourse, but able to complete sex
 - I can tolerate oral or manual stimulation only
 - Pain with intercourse prevents sex

Please mark the areas where you feel pain. If you are not having any pain, omit the following section.



Please rate your pain on a scale from 0 - 10, with 0 being no pain and 10 being the worst pain imaginable: _____



PELVIC FLOOR DISTRESS INVENTORY

NAME _____

DATE _____

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas but please fill out both sides of this form as completely as possible.

Do you experience, and if yes, how much are you bothered by....	Yes or No	Not at all	Somewhat	Moderately	Quite a bit
Usually experience pressure in the lower abdomen?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually experience heaviness or dullness in the pelvic area?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually have a bulge or something falling out that you can see or feel in your vaginal area?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually experience a feeling of incomplete bladder emptying?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Ever have to push on the bulge in the vaginal area with your fingers to start or complete urination?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				

Do you experience, and, if so, how much are you bothered by...	Yes or No	Not at all	Somewhat	Moderately	Quite a bit
Feel you need to strain too hard to have a bowel movement?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Feel you have not completely emptied your bowel at the end of a bowel movement?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually lose stool beyond your control if your stool is well formed?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually lose stool beyond your control if your stool is loose?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually lose gas from the rectum beyond your control?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Do you usually have pain when you pass your stool?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				

Do you experience, and if so, how much are you bothered by...	Yes or No	Not at all	Somewhat	Moderately	Quite a bit
Usually experience frequent urination?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually experience urine leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually experience small amounts of urine leakage related to coughing, sneezing, or laughing?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually experience small amounts of urine leakage (that is, drops)?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually experience difficulty emptying your bladder?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				
Usually experience pain or discomfort in the lower abdomen or genital region?	No <input type="checkbox"/> Yes <input type="checkbox"/> -->				

Urinary Distress Inventory 6 (UDI-6)