Advantage Physical Therapy Associates, LLC

Patient Information

Name (First, Middle Initial, Last)_____
Phone #:_____(M) or (H) _____
Address: _____
City: _____ State: ____ Zip Code: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Male □ Female □
Status: Single □ Married □ Other □ Occupation: _____
Patient Employer Information:
Name: _____ Phone No. (Including area code) _____
Spouse Information:
Spouse's Name: _____Date of Birth: _____
Employers Name: _____ Phone No. (Including area code) _____

Patient Emergency or Guardian Information:
Name: _____ Relationship: _____
Phone No. (Including area code) _____ Work or Home (circle only one)

How did you hear about us? (Please circle ONE and explain)
Doctor Friend/Family _____ Drive By Location _____
Previous Patient Website/Internet _____ Billboard/Where?_____
Phone Book Radio/ TV Newspaper _____
Other _____

Insurance Information:
Is your condition related to a: Car Accident? □Yes □No
Workers Compensation? □Yes □No
Primary Insurance: _____ ID#_____Group#_____
Insured's Name: _____ Date of Birth _____
If Applicable:
Secondary Insurance: _____ ID#_____Group#_____
Insured's Name: _____ Date of Birth _____

Referring Physician: _____ Phone Number: _____
Family Physician: _____ Phone Number: _____

Consent to Treat

I authorize Advantage Physical Therapy to examine and treat my condition as he/she deems appropriate through the use of therapy measures, and I give the authorization for these procedures to be performed. I have the right to informed participation in decisions involving my health care. This shall be based on clear, concise explanation of my condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed by my attending Therapist. I will not hold Advantage Physical Therapy responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I shall not be subjected to any procedure without my voluntary, competent, and understanding consent or the consent of my legally authorized representative. Where medically significant alternatives for care or treatment exist, I shall be informed. I shall be advised if Advantage Physical Therapy Associates proposes to engage in or perform human experimentation, for the purpose of research, affecting my care. I have the right to refuse to participate in such research projects.

After reading the above (or having it read to me), I hereby consent to receive therapy at Advantage Physical Therapy Associates, to begin on this date and terminating when determined by myself, my physician or my Therapist. I certify that the above information is true/correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information.

_____ _____
Patient/Guardian Signature Date

Acknowledgement of Receipt of Notice and Consent to Use and Disclose Health Information
Cancellation/No Show Policy

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **Advantage Physical Therapy Associates, LLC (APT)** to use and disclose health information about you for treatment, payment, and health care operations purposes. **APT** has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail to: Attention Privacy Officer
Advantage Physical Therapy Associates, LLC
2821 East Prospect Road York, PA 17402
Telephone: (717)840-1874
Facsimile: (717)840-0968

I have been offered and received or declined the Notice of Privacy Practices for Advantage Physical Therapy Associates. Advantage is authorized to use and disclose health information about: _____ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of Patient (or patient's personal representative) **Date**

Personal Representative Information (if applicable): _____ /_____
Name of personal representative Relationship to patient

YOU MAY PROVIDE THE NAMES OF TWO INDIVIDUALS THAT WE MAY COMMUNICATE WITH ABOUT YOUR MEDICAL TREATMENT:

Name/Relationship to Patient/Phone Number _____
Name/Relationship to Patient/Phone Number _____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE REGARDING ANY PERTINENT INFORMATION ABOUT YOUR TREATMENT? YES / NO

May we remind you about your scheduled appointments by e-mail? YES / NO
May we send your Home Exercise Program by email? YES / NO
Email Address: _____
Please note: Email addresses are used for internal purposes only. They will not be sold or shared with any other businesses or individuals

Cancellation/No Show Policy

Thank you for making Advantage Physical Therapy Associates your choice for therapy services. **In order to help you, we have found that consistent attendance is the key to our patients' success.** For this reason, all therapy sessions are important and cancellations/no shows are discouraged. Please take a moment to review the guidelines we have put in place to ensure that you get the most out of your experience at Advantage Physical Therapy:

- **In the event that you will be late for an appointment, please call as soon as possible to notify us of your expected arrival time. Please note that you may be asked to wait until your therapist is available.**
- **Please give at least 24 hour notice in the event of a cancellation. If you are unable to give 24 hour notice, please contact us as soon as possible.**
- **It will be up to the discretion of Advantage Physical Therapy to charge for repeated cancellations.**
- **No shows will be charged $50 for missed treatment sessions.**
- **Cancellation/No Show fees are not covered by insurance and must be paid before services are rendered. Cancellations due to illness or family emergency are excluded from this policy.**
  For Worker's Compensation and Auto insurance clients, we are obligated to inform your case manager of any missed treatment sessions.

I understand Advantage Physical Therapy Associates cancellation and no show policy and that it is my responsibility to plan appointments accordingly and notify Advantage if I cannot fulfill my scheduled appointments.

Patient Signature_____ Date: _____

www.gettheadvantage.org

FINANCIAL / PAYMENT POLICY

Thank you for choosing *Advantage Physical Therapy Associates* for your therapy needs. We are committed to providing the best treatment to all of our patients while maintaining a lawful and compliant facility. Our office has the following financial and payment policy to inform you of your responsibility and answer questions you may have regarding financial responsibility for services rendered.

1. **Insurance.** Advantage participates in most insurance plans. If I am not insured by a plan they are a contracted provider with, PAYMENT IN FULL is expected at the time services are rendered. My benefits for Physical and/or Occupational Therapy are obtained and provided to me as a courtesy, and knowing my benefit coverage is my responsibility. I will contact my insurance with any questions I have regarding coverage.
2. **Co-payments, Co-insurances, and Deductibles.** All co-payments and co-insurances MUST be paid by all patients *AT THE TIME OF SERVICE*. This arrangement is part of my contract with my insurance company.
3. **Non-covered Services.** I am aware that some of the services I receive may be ³non-covered ´or ³not considered medically necessary ´by my insurance company, therefore I will be responsible for the amount not covered per my insurance coverage.
4. **Proof of Insurance.** Advantage Physical Therapy must obtain a copy of my Y D O L Glicense and current insurance to provide proof of insurance and current address. If I fail to provide them with the correct information in a timely manner, I may be responsible for the balance of each claim at the time of my visit.
5. **Worker · V & R P S Hand Automobile Accidents.** Advantage will submit claims on my behalf to the Primary Insurance I elect, Auto Insurance, Worker's Compensation, and/or Personal Health Insurance. They will confirm the status of my Auto Insurance or Worker's Compensation claim as to "Open", "Closed", or "In Litigation", however they may not be provided the financial or coverage information, therefor they may not be able to determine the benefits / coverage available to me. They will verify my health insurance coverage as a courtesy in the case a denial is received from my primary carrier, all denied charges will be forwarded to my health insurance for consideration of payment. It is my responsibility to provide this information, otherwise charges denied by my worker ¶ V compensation, auto, or private insurance become my FULL RESPONSIBILITY and are due at receipt of your statement and time of service if treatment is still ongoing.
6. **Medicare and Secondary/Supplemental Plans.** Advantage Physical Therapy is a participating provider with Medicare, and they D F F H S W 0 H G L F D U H ¶ which according to its guidelines pays as follows for 2018: After the deductible of $183.00 is met, Medicare will pay 80% of the fee schedule, and it is my responsibility to pay the 20% co-insurance. If there is a secondary or supplemental plan, they may cover the 20% Medicare does not pay. It is my responsibility to contact my secondary or supplemental plan for coverage. As of January 1st 2018, Medicare has a set limit of $2010 for Physical Therapy and Speech Therapy combined. Services provided over these dollar amounts are not covered by Medicare and are your/the patient's responsibility. An ADVANCED BENFICIARY NOTICE or ABN will be issued for non-covered services, DURABLE MEDICAL EQUIPMENT or DME, and non-medically necessary treatment. Our Facility is not a DME provider therefore any DME item given (splints, supplies, etc.) will be considered a cash & carry item at the time of service.
7. **Claims Submission.** Advantage Physical Therapy will submit your claims to your primary and secondary insurance carrier(s), and assist you in any way reasonable to help get claims paid. I understand that my insurance company may need me to supply certain information directly. It is my responsibility to comply with their request in a timely fashion. I am aware that the balance of each claim is MY responsibility whether or not my insurance company pays my claim. My insurance is a contract between myself and my insurance company and Advantage Physical Therapy is not a party to that contract.
8. **Coverage Changes.** I understand that if my insurance changes, I will notify Advantage Physical Therapy before my next visit so they can make the appropriate changes to help receive my maximum benefits.
9. **Durable Medical Equipment/DME**. I understand this clinic is NOT a DME provider (supplies, splints, etc.). I will be responsible for payment of supplies at the time of service, if I have no DME coverage with my insurance.
10. **Nonpayment.** I understand that if my balance remains unpaid and is *over 90 days past due* Z L W K Q R U H V S R Q V H W R $ G Y D Q W D J H will refer MY account to a Collection Agency and I may be discharged from the practice. In addition to my outstanding balance, a minimum of a 30% surcharge P D \ E H D G G H G W R F R Y H U $ G Y D Q W D J H 3 K \ V L F D O 7 K H U D S \ ¶ V F R V W V F R O O H F W L R
11. **Methods of Payment:** Advantage accepts the following methods of payment: **Cash, Personal Check, Visa, MasterCard, Discover**. They also offer **Care Credit** which allows me to pay my balance over time with minimal to no annual fees or prepayment penalties. I understand that a **$40 fee** will charged for any personal check returned by my financial institution.

I HAVE READ AND UNDERSTAND THE FINANCIAL / PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

X_____ _____

PATIENT / GUARDIAN SIGNATURE **DATE**

Revised January 2018 AL

Advantage Physical Therapy Associates, LLC.

Health History

Name: _____ DOB:_____Height: _____Weight: _____
Leisure activities (including Exercise routines) _____
Occupation: _____
Are you on a work restriction from your doctor? □Yes □No
Are you latex sensitive? □Yes □No Do you smoke?(PQRS/OT) □Yes □No
Do you have a pacemaker? □Yes □No Are you pregnant or think you may be? □Yes □No

What brings you into our office today for evaluation? _____
How long have your symptoms been present?_____ How did the problem occur?_____
Treatments received so far for this problem (chiropractic, injections, etc)_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates: _____
_____

Have you had any of the following tests performed for your current problem/condition (please include dates):
X-rays □ Yes □ No *Nerve conduction test* □ Yes □ No *EMG* □ Yes □ No
CT Scan □ Yes □ No *MRI* □ Yes □ No _____

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe: (PQRS)

Your current level of pain while completing this survey: _____
The best your pain has been during the past week: _____
The worst your pain has been during the past week:_____

My symptoms currently: □Come and go □Constant □ Are constant, but change with activity.
What makes it worse? _____
What makes it better? _____

How are you currently able to sleep at night due to your symptoms?
□No problem sleeping □Difficulty sleeping □Awakened by pain □ Sleep only with medication

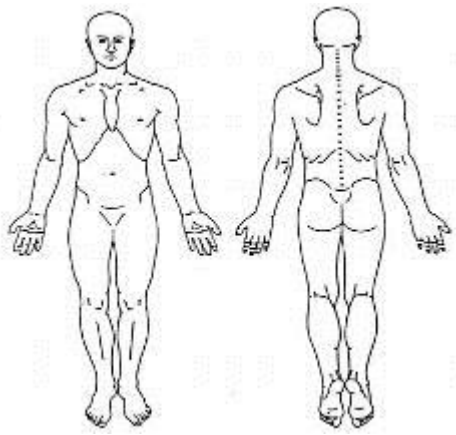
When are your symptoms worst? □Morning □Afternoon □Evening □Night □After exercise
When are your symptoms the best? □Morning □Afternoon □Evening □Night □After exercise

Have you ever had this problem before: □ Yes □ No When_____ Treatment received _____
How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ **Shooting/Sharp pain**
- O **Dull/Aching pain**
- × **Numbness**
- = **Tingling**



Advantage Physical Therapy Associates, LLC

Health History

Allergies:
List any medications you are allergic to: _____
Have you RECENTLY noted any of the following: (Check all that apply)

□fatigue	□numbness or tingling	□gout
□fever/chills/sweats	□muscle weakness	□nausea/vomiting
□hernia	□dizziness/lightheadness	□shortness of breath
□fainting	□difficulty maintaining balance while walking	
□bone fracture/joint injury		□falls
□headaches		

Have you EVER been diagnosed with any of the following conditions (Check all that apply)

□cancer- what type/when? _____	□depression	□heart problems	□lung problems
□diabetes	□chest pain/angina	□tuberculosis	□osteoporosis
□high blood pressure	□multiple sclerosis	□asthma	□circulation problems
□rheumatoid arthritis	□epilepsy	□blood clots	□other arthritic condition
□stroke	□anemia	□liver problems	□bone or joint infection
□chemical dependency (i.e. alcoholism)	□high cholesterol	□pneumonia	□hepatitis
□human immunodeficiency virus *(HIV)*	□STD	□Other _____	

During the past month have you been feeling down, depressed or hopeless? **(PQRS/OT)** □Yes □No
During the past month have you been bothered by having little interest or pleasure in doing things? **(PQRS/OT)** □Yes □No
Is this something with which you would like help? **(PQRS/OT)** □Yes □Yes, but not today □No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **(PQRS/OT)** □Yes □No
Have you FALLEN in the PAST YEAR? Please circle one of the following number options: (PQRS)
1.) I have not fallen in the past year.
2.) I have only fallen 1 time in the past year and had no injury with that fall.
3.) I have fallen 1 time in the past year and I had an injury with that fall.
4.) I fell 2 times in the past year.

Please list any medication you are currently taking (including pills, injections, and/or skin patches: **(PQRS)** _____
_____ _____(PT Initials)
Have you ever taken steroid medications for any medical conditions? □Yes □No
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? □Yes □No

Previous History of:

Physical Therapy**:**	□Yes	□No	Date: _____
Chiropractic:	□Yes	□No	Date: _____
Occupational Therapy:	□Yes	□No	Date: _____
Speech Therapy:	□Yes	□No	Date: _____
Home Health Care:	□Yes	□No	Date: _____
Other Therapy:	□Yes	□No	Date: _____

My signature verifies the above information is true and correct to the best of my knowledge.

_____
Signature/Guardian Date

_____
Physical/Occupational Therapist Signature Date

Advantage Physical Therapy Associates, LLC

Name:_____ Date:_____

On a scale from 1-10, please rate the below activities based on your ability to complete them on your own without falling. (Assisted device may be used)

Falls Efficacy Scale

Take a bath or shower

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Reach into cabinets or closets

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Walk around the house

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Prepare meals not requiring carrying heavy or hot objects

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of bed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Answer the door or telephone

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of a chair

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting dressed and undressed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Personal grooming (i.e. washing your face)

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting on and off of the toilet

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident