



We are committed to excellence in rehabilitation, injury prevention, sports performance and wellness utilizing hands-on physical therapy techniques and evidence-based exercise prescription. Our passion is to help you achieve life-changing results. www.advantageptsp.com

PATIENT REGISTRATION

Patient's LEGAL Name _____
First Middle Initial Last Call by/Nickname

Permanent Address _____

City _____ State _____ Zip _____

Mailing Address (leave blank if same) _____

City _____ State _____ Zip _____

E-mail _____ @ _____ Newsletter, check here. Social Security Number _____ - _____ - _____

Phone Numbers (H) _____ (C) _____ (W) _____

Date of Birth ____/____/____ Age _____

Spouse/Person to Contact in Case of Emergency _____

Phone _____ Alternate Phone _____

Nearest relative not living with you _____ Phone _____

Referring Physician _____ Primary Care Physician _____ Date of Injury ____/____/____

Person who recommended services if other than physician: _____

- Word of mouth Previous Patient Web Family Talk Newspaper Radio

Is this Worker's Comp? ____ If yes, contact person _____ Phone# _____

Employer _____ Phone _____

Address _____

Assignment of Benefits

I authorize payment of medical benefits to Advantage Physical Therapy for professional services rendered.

Signed _____ Date _____

Release of Information

May we leave a message on your answering machine? Yes _____ No _____

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment below. In addition, I authorize my information to the following:

___ Attorney _____ Doctors _____ Schools/ATC _____

___ Spouse _____ Other _____

Signed _____ Date _____

(GUARANTOR INFORMATION AND AUTOMOBILE ACCIDENT VICTIMS, CONTINUE ON BACK)

INSURANCE POLICY HOLDER INFORMATION

The information below is needed if you, the patient, are not the policy holder for your insurance plan. This information is needed in order for your claims with our office to be processed correctly. Thank you very much for your time!

Name: _____
First M.I. Last

Address: _____

Email: _____

SS#: _____ Home #: _____

Work #: _____ Cell #: _____

Date of Birth: _____ Gender: Male _____ OR Female _____

Relationship to policy holder: Spouse _____ Child _____ Employee/Employer _____ Other _____

AUTOMOBILE ACCIDENT INJURY

Date of Accident _____

Location of Accident _____

Your car insurance policy is with _____

Policy# _____

Agent Name _____

Name of driver of other vehicle _____

Their car insurance policy is with _____

Policy # _____ Agent Name _____

Who has been responsible for paying your medical bills so far? _____

Lawyer handling Case _____

Address _____

Phone # _____ Fax # _____

Special Instructions _____

MEDICAL PROFILE

(If you do not understand a question, leave it blank and your therapist will assist you).

NAME: _____ LEISURE ACTIVITIES: _____
 OCCUPATION: _____
 Estimated height _____ Estimated Weight _____

ALLERGIES: List any medication(s) you are allergic to: _____
 Are you latex sensitive? Yes No List any other allergies we should know about _____
 Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please check (v) any of the following whose care you are currently under or have been under within the past year:

___ Medical doctor (MD)	___ Psychiatrist/Psychologist	Other _____
___ Osteopath	___ Physical Therapist	_____
___ Dentist	___ Chiropractor	_____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

Have you or anyone in your immediate family (parents, brothers, sisters) ever been diagnosed or treated for any of the following?

Circle all that apply and specify what kind and who?

	Self	-- Family	-- Specify
Cancer Type _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
-- Are you on insulin?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other arthritic problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

For Office Use

Have you recently noticed any of the following?

Circle those that apply

- Weight loss/gain
- Nausea/vomiting
- Fatigue
- Weakness
- Fever/chills/sweats
- Numbness or tingling

MEDICAL PROFILE

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, include approximate date and reason for the surgery or hospitalization:

DATE	REASON FOR SURGERY/HOSPITALIZATION
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Circle those that apply

- Aspirin
- Tylenol
- Advil/Motrin/Ibuprofen
- Laxatives
- Decongestants
- Antihistamines
- Antacid
- Vitamins/mineral supplements
- Other _____



Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____ How many drinks per setting? _____

How many days per week do you use illegal drugs? _____

Social information

With whom do you live? _____

Does your residence have: Stairs? Yes No How many? _____ Hand rails? Yes No
Assistive modifications: (Access ramps, Bathroom rails, etc) List _____

Do you have: (circle all that apply) Cane walker wheelchair glasses hearing aids

Do you have difficulty with: Self care (bathing, dressing, etc) Yes No Explain _____

Home management (chores, shopping, etc) Yes No Explain _____

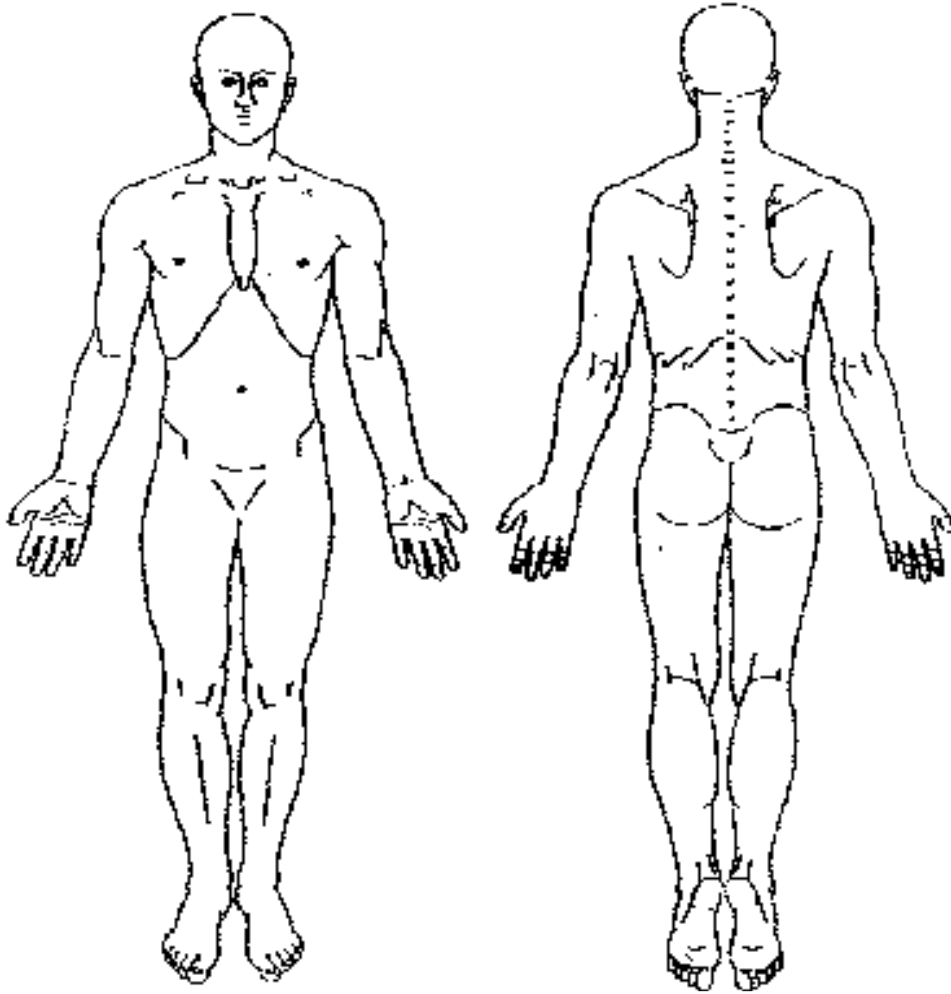
Patient/Client signature: _____ **Date:** _____

Therapist signature: _____ **Date:** _____

PAIN DIAGRAM & PAIN RATING SCALE

Instructions: Indicate where your pain is located and what type of pain you feel at the present time. Use the following symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

/// Aching or Stabbing	XXX Burning	000 Pins and Needles	=== Numbness
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HOW MUCH PAIN DO YOU HAVE?

CIRCLE the number below that indicates how bad your pain is **TODAY**

No Pain At All (0---1---2---3---4---5---6---7---8---9---10) Pain requires immediate emergency care

Write in the number that indicates the least pain you have experienced in the last two weeks_____

Write in the number that indicates the worst pain you have experienced in the last two weeks_____

PATIENT RESPONSIBILITY

- As a patient of Advantage Physical Therapy or financial responsible party, I agree that I am responsible for any unmet deductible, co-insurance and/or any unpaid balances. This includes all insurance companies, workman’s compensations, and auto claims.
- Medicare patients who do not have supplemental insurance coverage are responsible for any unmet deductible, non-covered services, or co-insurance amounts.
- All uninsured patients, patients who are denied physical therapy coverage by their insurance company, and patients that have exhausted their insurance benefits, but still require advanced care are responsible for the fee for service amount based on treatment provided.
- Any remaining balance that is the responsibility of the patient is subject to an interest rate of 1.5 percent per month if unpaid following the 1st billing cycle.
- I understand if payment arrangements have not been made, and my account is still outstanding (90 days from the 1st billing cycle, my account may be referred to a collection agency or an attorney for collection. I agree to pay all costs of collection, including but not limited to, 40% collection fees, registered mail fees, court cost actually incurred in the collection of the account whether or not a suit is filed, and any other fees or cost incurred during the collections process.
- I understand that I am responsible for my account even if I receive a late notification of my outstanding balance. In this case, I will not be referred to a collection agency and will be allowed to make arrangements for a payment plan.

“NO SHOW” FOR APPOINTMENT

(WITHOUT NOTIFICATION)

If you are unable to keep your appointment we would like to be notified **24 hours before** your scheduled appointment. If we do not receive a notification of your cancellation prior to your appointment, a \$35.00 “No Show/ No Call” charge will be added to your account and due in full at the time of your next scheduled appointment. **This charge is not covered by any insurance.**

I have read and agree to the above statements.

_____ Date _____

Signature of patient/responsible party



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PRIVACY NOTICE SUMMARY

ALL MEDICAL INFORMATION ABOUT YOU IS REGARDED AS PROTECTED HEALTH INFORMATION (PHI) AND IS TREATED AS CONFIDENTIAL AND WILL BE RELEASED ONLY TO THOSE AUTHORIZED TO RECEIVE IT.

PROTECTED HEALTH INFORMATION WILL BE DISCLOSED FOR **TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)** TO:

- YOU OR SOMEONE YOU HAVE APPROVED TO RECEIVE IT AND/OR SOMEONE THAT HAS THE LEGAL RIGHT TO ACT IN YOUR BEHALF.
- MEDICARE, HEALTH INSURANCE PLANS, WORKERS COMPENSATION INSURANCE AND OTHER PAYERS, FOR BILLING PURPOSES.
- REFERRING MEDICAL PRACTICES TO REPORT EVALUATIONS, TREATMENTS, PROGRESS, RECOMMENDATIONS AND DISCHARGE.
- INTERNS AND/OR STUDENTS PURSUING A CAREER IN PHYSICAL THERAPY THAT ARE TEMPORARILY PRESENT IN THE PRACTICE.
- WHERE REQUIRED BY FEDERAL, STATE OR LOCAL LAW.

APTSP MAY USE OR GIVE OUT PROTECTED HEALTH INFORMATION FOR THE FOLLOWING PURPOSES UNDER LIMITED CIRCUMSTANCES:

- FOR JUDICIAL AND ADMINISTRATIVE PROCEEDINGS IN RESPONSE TO COURT ORDER,
- FOR RESEARCH STUDIES THAT MEET ALL PRIVACY LAW REQUIREMENTS,

YOUR AUTHORIZATION (SIGNATURE) IS REQUIRED TO USE OR GIVE OUT YOUR PROTECTED HEALTH INFORMATION FOR ANY PURPOSE THAT IS NOT SET OUT IN THIS NOTICE.

YOUR AUTHORIZATION (SIGNATURE) IS REQUIRED TO LIMIT THE DISCLOSURE OF PHI BY IDENTIFYING TO WHOM IT SHALL NOT BE RELEASED AND/OR THE CONTENT THAT SHALL NOT BE RELEASED.

UPON REQUEST TO THE OFFICE MANAGER, ARRANGEMENTS CAN BE MADE FOR YOU TO REVIEW OR RECEIVE A COPY OF YOUR MEDICAL INFORMATION (PHI). IF THERE IS ANY CONCERN REGARDING THIS INFORMATION, AN APPOINTMENT WILL BE SCHEDULED WITH THE ATTENDING PHYSICAL THERAPIST TO DISCUSS THE CONCERN. THE INFORMATION MAY BE AMENDED WHEN DEEMED APPROPRIATE.

UPON REQUEST YOU MAY RECEIVE AN ACCOUNTING OF DISCLOSURES. THIS IS A LIST TO WHOM INFORMATION HAS BEEN RELEASED.

SUBMIT ALL REQUESTS TO THE OFFICE MANAGER.

A COPY OF THIS NOTICE OR THE COMPLETE PRIVACY NOTICE IS AVAILABLE UPON REQUEST.

PATIENT SIGNATURE

DATE

Harrisonburg



Weyers Cave

