

1. Describe your symptoms _____

2. Date symptoms began _____

3. How did the symptoms start? _____

4. How often do you experience your symptoms?

_____ Constantly (76-100% of the day)

_____ Frequently (51-75% of day)

_____ Occasionally (26-50% of day)

_____ Minimally (0-25% of day)

5. How are your symptoms changing?

_____ No change

_____ Getting Better

_____ Getting Worse

6. During the past 4 weeks (or since onset of symptoms): rate symptoms from 0 (none) to 10 (unbearable) as follows:

What has been the average intensity? 0 1 2 3 4 5 6 7 8 9 10

What has been the best/lowest intensity? 0 1 2 3 4 5 6 7 8 9 10

What has been the worst/highest intensity? 0 1 2 3 4 5 6 7 8 9 10

7. Had you had similar symptoms in the past? Yes _____ No _____

a. What treatment did you receive and when? _____

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

X-rays _____ MRI _____ CT SCAN _____ EMG _____

Results: _____

Do you have active Tuberculosis? Yes No

Have you been exposed to active Tuberculosis? Yes No

Do you have any of the following conditions?

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Smoker | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Heat/Cold Reaction |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Bone Disease | <input type="checkbox"/> History of Polio | <input type="checkbox"/> Connective Tissue Disease |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other _____ | | |

None of the Above _____

List current medications: _____

Allergies: _____

Patient Goals Decreased Pain Return to Daily Activities Return to Work
 Other _____

Current Employer: _____ Job Title: _____

Work Status: _____ Full _____ Light _____ Not Working

Job Requirements: _____

Therapist use only: _____

PATIENT NAME/DOB:



Billing Policies

Please contact your insurance company for your specific benefit information. Charges for outpatient Physical / Occupational Therapy are usually covered under your health insurance. Advanced Physical Therapy will bill your insurance company for you as a complimentary service. We do ask that you pay your co-pay at the time of service.

All charges incurred at Advanced Physical Therapy are the responsibility of the patient. Any portion of your bill that is not paid by your insurance company, including non-covered services and supplies, and co-insurance will be billed to you and is due upon receipt. All returned non-sufficient funds checks will be charged \$20.00.

Our office will not accept responsibility for negotiating a settlement on a disputed claim. Accounts that have received at least two patient statements with no response will be charged a \$20.00 late fee. Past due accounts will be transferred to a collection agency. Any accounts transferred to the agency will be assessed all reasonable costs or collection agency fees, attorney's fees and court costs. These additional costs will be added to the original outstanding balance due.

If necessary our business office will assist you in setting up a payment plan for the balance on your account not paid by insurance.

There will be a \$20.00 charge for any no-show or for a cancellation with less than 4 hours notice prior to the scheduled appointment time.

AUTHORIZATION STATEMENT

I AUTHORIZE AND CONSENT TO TREATMENT AT ADVANCED PHYSICAL THERAPY.

I AUTHORIZE RELEASE OF ANY INFORMATION TO MY PHYSICIAN AND INSURANCE COMPANY.

I AUTHORIZE ALL PAYMENTS FROM MY INSURANCE COMPANY BE MADE PAYABLE TO ADVANCED PHYSICAL THERAPY.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF ADVANCED P HYSICAL THERAPY'S NOTICE OF PRIVACY PRACTICES THAT DESCRIBES MY RIGHTS AND ADVANCED PHYSICAL THERAPY'S DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION.

PATIENT (Please Print) _____ DOB: _____

PATIENT'S SIGNATURE _____ DATE: _____

GUARANATOR'S SIGNATURE _____ DATE: _____