



creating an environment for wellness and healing

<b>Last Name</b>		<b>First Name</b>		<b>Middle Initial</b>	<b>Today's Date</b>	<b>E-Mail Address</b>	
<b>Street</b>				<b>City</b>		<b>State</b>	<b>Zip code</b>
<b>Date of Birth</b>	<b>Social Security #</b>	<b>Gender</b>		<b>Home Phone</b>		<b>Cell Phone</b>	
		<input type="radio"/> Male <input type="radio"/> Female					
<b>Would you like a reminder call?</b>					<b>Marital Status</b>		
<input type="radio"/> Yes Cell <input type="radio"/> Yes Home <input type="radio"/> Yes Work <input type="radio"/> No					<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Other		
<b>Spouse's Name</b>		<b>Date of Birth</b>	<b>Emergency Contact</b>		<b>Relation</b>	<b>Phone #</b>	
<b>Current Employer</b>		<b>Phone#</b>	<b>Referring Physician</b>		<b>Reason for Visit</b>		
<b>How did you hear about us?</b>			<b>Have you seen or heard our radio and television ads?</b>				
<input type="radio"/> Physician <input type="radio"/> Yellow Pages <input type="radio"/> Event <input type="radio"/> Print Ad <input type="radio"/> Presentation <input type="radio"/> Friend			<input type="radio"/> Yes – Channel 11 Ad <input type="radio"/> Yes – Radio Ad <input type="radio"/> No				
<b>Primary Insurance</b>		<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip code</b>
<b>Phone #</b>		<b>Policy #</b>		<b>Group #</b>		<b>Guarantor/Policy Holder Name</b>	
<b>Guarantor/Policy Holder Relationship to you</b>				<b>Guarantor/Policy Holder Date of Birth</b>			
<b>Secondary Insurance</b>		<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip code</b>
<b>Phone #</b>		<b>Policy #</b>		<b>Group #</b>		<b>Guarantor/Policy Holder Name</b>	
<b>Guarantor/Policy Holder Relationship to you</b>				<b>Guarantor/Policy Holder Date of Birth</b>			
<b>WC/Auto Insurance</b>		<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip code</b>
<b>Claim #</b>		<b>Adjuster's Name</b>		<b>Phone #</b>		<b>Date of Injury</b>	
<b>Employer at time of injury (WC Only)</b>				<b>Accident State (Auto Only)</b>			

PLEASE PAY COPAY AT EVERY VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.  
 FOR ANY BILLING QUESTIONS 907-743-8228 OR 800-641-6940.

I understand that I am responsible for all fees regardless of insurance coverage and that all charges are due at time of service. I am responsible for furnishing all insurance information correctly prior to treatment unless other arrangements have been made in advance. I authorize advanced physical therapy to examine me, administer treatment as necessary and perform procedures that are considered therapeutically or diagnostically necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## **REHABILITATION PROGRAM**

Following your evaluation, your therapist will discuss your **diagnosis, treatment program and plan** as well as the **potential for improvement and frequency and duration** of your program. Normally, treatments can last from **30 minutes to 1 hour**. Please keep your therapist informed of your **next doctor visit**, hopefully at least 2 days prior to the visit, so that we may retest you prior to your visit and share the results with your physician.

Your **exercise program** will be upgraded as you progress, usually each visit. You will also be given a Home Exercise Program. Both programs are vital to your success. The **primary goal** of the program is to decrease pain, increase flexibility, strength, and endurance, as well as general function. Another goal is to educate you and enable you to return to work, seek employment, or return to your previous level of activity.

**Cold water** is available during your exercise program. Please ask any staff member if you need help. **Smoking** is only allowed outside at rear exit at least 20 feet from the door entrances.

**Patients will be discharged** from the program for the following reason(s): a) goals are met; b) compliance problems- exercise absences, tardiness, or lack of cooperation/poor motivation; c) lack of progress; d) other medical complications.

## **No Show and Cancellation Policy**

### **NO SHOW:**

#### **Definition:**

A no show is defined as any patient that does not show to their scheduled appointment, and no phone call was given to cancel the appointment.

#### **Policy:**

A patient who no shows to 2 appointments in a row, is taken off the schedule for all remaining scheduled appointments. The patient remains a patient with Advanced Physical Therapy, however, and is welcome to make same day appointments. If the patient has a chronic no show history, 2 or more times (not consecutive) within 6 scheduled visits, the physical therapist and clinical director are advised of the problem and will meet to discuss the status of the patient.

### **CANCELLATION:**

#### **Definition:**

A cancellation is defined as a same day call in to cancel the appointment.

#### **Policy:**

There is no charge for a cancelled appointment.

A patient who chronically cancels is one who cancels appointments at a frequency of equal to or greater than 1 of every 3 scheduled appointments. In any given treatment period, cancellations for illness or unexpected emergencies can be expected. Chronic cancellation is equal to or greater than 4 cancellations within 12 scheduled visits.

**Signature of person completing this form** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_ **self** or \_\_\_\_\_ **Date** \_\_\_\_\_



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## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ acknowledge that I have received a copy of ADVANCED PHYSICAL THERAPY'S Notice of Privacy Practices. This notice describes how ADVANCED PHYSICAL THERAPY may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I am aware and agree that ADVANCED PHYSICAL THERAPY may use or disclose my health information for research purposes under certain limited circumstances, and that in the event that my medical records are requested by a third party, I or my appointed legal guardian, must sign a medical release form in order to distribute that information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_