advanced physical therapy

creating an environment for wellness and healing

Is this a WC or Auto Insurance Claim? ___________

Please read, correct and/or add additional information as needed and initial.

Last Name	First Name	Middle Initial	Today's Date	E-Mail Address

Address	City	State	Zip code

Date of Birth	Social Security #	Gender	Day Phone	Evening Phone

Would you like a reminder call?	Marital Status
○ Yes Cell ○ Yes Home ○ Yes Work ○ No ○ **Leave a detailed message regarding my appointment**	

Spouse's Name	Spouse's DOB	Emergency Contact	Relation	Phone #

Current Employer	Phone#	Referring Physician	Reason for Visit

How did you hear about us?			Have you seen or heard our radio and television ads?	
○ Physician	○ Yellow Pages	○ Event	○ Yes – Channel 11 Ad	○ Yes – Radio Ad
○ Print Ad	○ Presentation	○ Facebook	○ No	

If you were referred by a friend, please share their name so we can thank them: ____________________

Primary Insurance	Address	City	State	Zip code

Phone #	Policy #	Group #	Guarantor/Policy Holder Name

Guarantor/Policy Holder Relationship to you	Guarantor/Policy Holder Date of Birth

Secondary Insurance	Address	City	State	Zip code

Phone #	Policy #	Group #	Guarantor/Policy Holder Name

Guarantor/Policy Holder Relationship to you	Guarantor/Policy Holder Date of Birth

WC/Auto Insurance	Address	City	State	Zip code

Claim #	Adjuster's Name	Phone #	Date of Injury

Employer at time of injury (WC Only)	Accident State (Auto Only)

○ **Please check the circle if have insurance through the Affordable Care Act (ACA)**

I authorize advanced physical therapy to examine me, administer treatment as necessary and perform procedures that are considered therapeutically or diagnostically necessary.

Signed: ______________________________________ Date: ____________

Relationship to client: ______self or __________________ Date: ____________

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ATTENDANCE POLICY

Our intent is to maintain integrity of the clinical schedule and ensure that each client's plan of care is fulfilled. Every attempt will be made to maintain continuity of care and accommodate client scheduling needs. Repeated no-shows or frequent cancellations without sufficient notice (same day cancellations) are not consistent with the plan of care and disrupt the clinical schedule.

We require a 24-hour notice **for all cancellations and failure to give such a notice will result in a $50.00 fee which is the patient's responsibility.**

Not adhering to scheduled appointments is defined as 2 or more subsequent no-shows or frequent incidents of same day cancellations. Non-adherence will result in the removal of remaining appointments from the schedule and determination by primary physical therapist or clinical director for further scheduling.

RELEASE OF INFORMATION

I authorize the release of information to the following individuals. I understand that only the individuals listed below will be able to obtain information regarding myself (including date and time of appointments).

________________________________ ____

________________________________ ____

________________________________ ____

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.

By signing below, I am agreeing to the Attendance Policy, Release of Information and the Notice of Privacy Practices

Signed: ____ Date: ______________

Relationship to client: ______self or ____________________ Date: ______________