TO ENSURE YOU RECEIVE A COMPLETE AND THOROUGH EVALUATION, PLEASE PROVIDE US WITH IMPORTANT INFORMATION ON THIS FORM. IF YOU DO NOT UNDERSTAND THE QUESTION, PLEASE ASK FOR ASSISTANCE. THANK YOU.

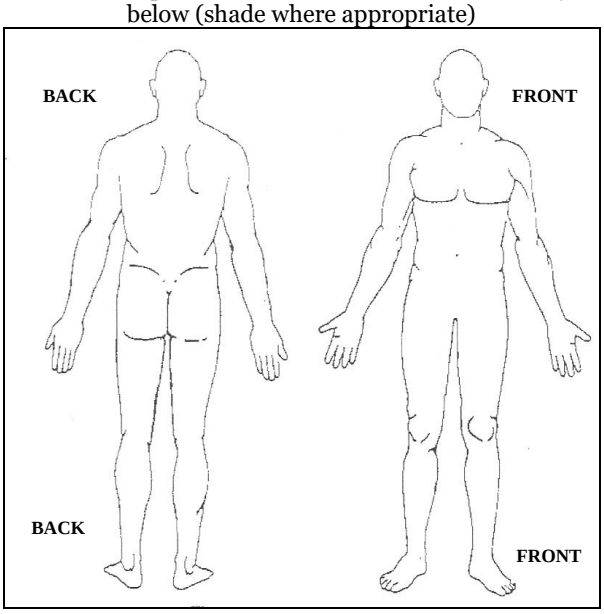
HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

_____

_____

Localize areas of pain or abnormal sensation on the body chart below (shade where appropriate)



2. Please indicate on the scale below the worst your pain has been in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain imaginable

3. When did your symptoms begin? _____
(Please indicate a specific date if possible.) If surgery or accident, please indicate date _____

4. Which of the following best describes how your injury occurred? (If your condition is post surgical, please indicate as per your original injury.

☐ lifting ☐ degenerative process ☐ overuse

☐ car accident ☐ recreation/sports

☐ trauma/accident ☐ other _____

5. Since onset, have your symptoms:

☐ improved ☐ worsened ☐ not changed

6. Have you had similar symptoms in the past? ☐ yes ☐ no
How many episodes? _____

7. Check all that apply to describe the nature of your symptoms.

☐ burning ☐ tingling ☐ numb ☐ cramping

☐ sharp ☐ dull ☐ aching ☐ throbbing

☐ occasional ☐ constant ☐ periodic

☐ other _____

8. As the day progresses, do your symptoms:

☐ worsen ☐improve ☐ remain the same

9. In what position do you sleep?

☐ right side ☐ left side ☐ stomach

☐ back ☐ back/sides/stomach ☐ chair/recliner

10. What aggravates your symptoms?

☐ sitting ☐ standing ☐ up/down stairs

☐ walking ☐ sleeping ☐ sitting to standing

☐ squatting ☐ stress ☐ standing to sitting

☐ coughing/sneezing ☐ reaching across body

☐ reaching overhead ☐ reaching behind back

☐ taking a deep breath ☐ reaching in front of body

☐ bending ☐ looking overhead

☐ household activities ☐ recreational activities

☐ other _____

11. What relieves your symptoms?

☐ heat ☐ sitting ☐ standing

☐ cold/ice ☐ rest ☐ stretching

☐ walking ☐ medication ☐ massage

☐ exercise ☐ lying down ☐ nothing

☐ other _____

12. Check previous treatments you have had for this condition.

☐ none ☐ oral medication

☐ exercise ☐ TENS unit ☐ biofeedback/hypnosis

☐ traction ☐ bracing/taping/casting

☐ bed rest ☐ acupuncture ☐ spinal/muscle injection

☐ chiropractic ☐ physical therapy

☐ hospitalization/dates _____

Advance Physical Therapy

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PATIENT QUESTIONNAIRE/HEATLH HISTORY

Name _____

Date _____ **Ref MD** _____.

13. Check any of the following diagnostic tests that you have had performed for this current condition.

☐ none ☐ x-ray ☐ MRI

☐ other _____

14. What are your goals from physical therapy?

_____

_____

15. Do you have a specific time frame in mind for reaching these goals? ☐ yes ☐ no

How long?_____ ☐ days ☐ weeks ☐ months

16. In order to get better, you will be expected to participate in your treatment. This may include doing exercises (here and/or at home) or avoiding certain activities. How committed are you to participating in your treatment?

☐ very ☐ somewhat ☐ not very

MEDICATION

Please list any prescription medications that you are currently taking (pain pills, injection, skin patches, etc.) Attach a separate sheet if necessary_____

_____

_____

List any over the counter medications that you are currently taking_____

_____

ALLERGIES/PRECAUTIONS

List any allergies to food, medications or topical agents:_____

_____

_____

Are you, or could you be, pregnant? ☐ yes ☐ no

Do you have a pacemaker or other implantable device?

☐ yes ☐ no

Other conditions/situations that may affect your care or progress:

_____

_____

WORK HISTORY

Occupation_____

☐ employed full time ☐ employed part time

☐ self employed ☐ homemaker

☐ student ☐ retired ☐ unemployed

Does this condition affect your work status in any way?

☐ yes ☐ no

Physical activities at work (check all that apply)

☐ sitting ☐ standing ☐ phone use

☐ heavy lifting ☐ driving ☐ repetitive bending

☐ computer use ☐ heavy equipment operation

☐ other _____

Are you currently receiving or seeking disability for this condition? ☐ yes ☐ no

If not performing your normal activities at work, do you plan to return to your previous activity level? ☐ yes ☐ no

LIVING SITUATION

☐ live alone ☐ live with: _____

☐ private home with stairs ☐ private home, no stairs

☐ assisted living

Emergency contact name:_____

Emergency contact phone: _____

GENERAL HEALTH

How would you rate your general health?

☐ excellent ☐ average ☐ poor

Do you exercise outside of normal daily activities? ☐ no

☐ 3+ days/week ☐ 1-3 days/week ☐ rarely

Exercise, sports/recreation consisting of_____

_____

Do you drink caffeinated beverages? ☐ yes ☐ no

Do you smoke? ☐ yes ☐ no *packs per day*_____

What is your stress level? ☐ low ☐ medium ☐ high

PAST MEDICAL/PAST FAMILY HISTORY

Have you (**P**) or an immediate family member (**F**) ever been diagnosed with any of the following conditions?

☐ arthritis **P F** ☐ osteoporosis **P F**

☐ headaches **P F** ☐ stroke **P F**

☐ heart problems **P F** ☐ high blood pressure **P F**

☐ cancer **P F** (type)_____

☐ epilepsy/seizures **P F** ☐ Parkinson's **P F**

☐ diabetes **P F** ☐ kidney problems **P F**

☐ thyroid problems **P F** ☐ circulatory problems **P F**

☐ depression **P F**

List any surgeries you have had related to your current problem.

_____

_____

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PATIENT_____

SOC_____ ***REF MD***_____

ADVANCE PHYSICAL THERAPY

SYSTEMS REVIEW

Since onset of *this current condition*, have you experienced any of the following symptoms (either new or aggravation of chronic problem)? Check all that apply.

General ☐ fever ☐ chills ☐ weight changes ☐ fainting ☐ appetite changes ☐ lethargy ☐ sleep changes ☐ fatigue

Musculoskeletal ☐ joint pain ☐ muscle pain ☐ muscle cramps ☐ fractures ☐ swelling ☐ arthritis ☐ weakness

Neurological ☐ dizziness ☐ tremors ☐ lack of coordination/balance ☐ tension ☐ headaches ☐ numbness/tingling

Cardiovascular ☐ chest pain ☐ shortness of breath ☐ irregular pulse ☐ hypertension ☐ numbness of extremities

Respiratory ☐ wheezing ☐ asthma ☐ shortness of breath ☐ cough

Gastrointestinal ☐ nausea ☐ vomiting ☐ heartburn ☐ painful bowels ☐ diarrhea ☐ constipation ☐ abdominal pain

Genitourinary ☐ urinary pain ☐ urinary frequency ☐ burning on urination ☐ sexual difficulty ☐ incontinence

Integumentary (skin) ☐ rashes ☐ sores ☐ scars ☐ pain ☐ masses/ lumps

Endocrine ☐ sweating ☐ voice changes ☐ thirst

Eyes ☐ pain ☐ spots ☐ twitching ☐ blurred vision

Ears, nose, mouth, throat ☐ pain ☐ nose bleeds ☐ sores ☐ noise sensitivity ☐ ringing in ears

Psychiatric ☐ depression ☐ anxiety ☐ emotional instability ☐ memory loss

Hematologic/Lymphatic ☐ bruising ☐ fatigue ☐ enlarged glands ☐ phlebitis ☐ anemia

FUNCTIONAL ASSESSMENT - BASELINE

Please circle the level of difficulty you have TODAY for each of the activities listed below.	**Able to do without difficulty or pain**	**Able to do with little difficulty or pain**	**Able to do moderate difficulty or pain**	**Able to do with much difficulty or pain**	**Unable to do**	**Comments**
Lying flat	1	2	3	4	5	
Rolling over	1	2	3	4	5	
Lying to sitting	1	2	3	4	5	
Sitting	1	2	3	4	5	
Sitting to standing	1	2	3	4	5	
Standing to sitting	1	2	3	4	5	
Squatting	1	2	3	4	5	
Bending/stooping	1	2	3	4	5	
Balancing	1	2	3	4	5	
Kneeling	1	2	3	4	5	
Walking-short distance	1	2	3	4	5	
Walking- long distance	1	2	3	4	5	
Climbing stairs (single step)	1	2	3	4	5	
Climbing stairs (more than 5)	1	2	3	4	5	
Going down stairs	1	2	3	4	5	
Walking outdoors – uneven terrain	1	2	3	4	5	
Sleeping	1	2	3	4	5	
Transitional movements	1	2	3	4	5	
Pushing	1	2	3	4	5	
Pulling	1	2	3	4	5	
Reaching out front	1	2	3	4	5	
Reaching overhead	1	2	3	4	5	
Reaching back	1	2	3	4	5	
Grasping	1	2	3	4	5	
Lifting	1	2	3	4	5	
Carrying	1	2	3	4	5	
Personal care (washing, dressing)	1	2	3	4	5	
Driving	1	2	3	4	5	
Hopping/Jumping	1	2	3	4	5	
Running	1	2	3	4	5	

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PATIENT _____ ***SOC*** _____ ***REF MD*** _____

ADVANCE PHYSICAL THERAPY

9362 W. Overland Rd. • Boise, Idaho 83709 • (208)672-8144 • Fax (208)672-8145
www.aptorthosports.com • aptboise@aol.com

BILLING AND INSURANCE POLICIES OF ADVANCE PHYSICAL THERAPY

INSURANCE BILLING POLICY

We are pleased to offer you our insurance billing service. We accept Medicare and Medicaid assignment, and are participating members of many insurance plans. We will file insurance claims on your behalf with your insurance programs. We will also bill Worker's Compensation, auto insurance, and will accept liens with your attorney. As such, we will require a copy of your current insurance ID card(s) and completion of all required paperwork. Without this information, we will be unable to assist you in the billing process. Please keep us informed of any changes to your personal and/or insurance information.

APT is required by law to collect deductibles, co-payments and cost shares when these are part of your insurance plan/contract. Payment is expected at the time of service unless other arrangements have been made. *We will strive to collect payment directly from your third party payer, but please keep in mind that patients are ultimately responsible for their bills, not just co-payments, deductibles, and any cost shares. You will receive periodic statements on your account that may not reflect insurance payments as these may still be pending. However, unpaid co-pays and cost shares reflected on statements should be promptly remitted.*

PAYMENT OPTIONS

In recognition that resources for health care are often limited, APT offers these payment options:
Payment by cash, check, money order or credit card (Discover, MasterCard, or Visa).
Payment plan arranged with office manager.
Request for financial hardship adjustment (requires additional paperwork).

LATE PAYMENTS/NO SHOWS/CANCELLATIONS/RETURNED CHECKS

Any balances not paid in a timely manner (typically within 60 days) may be subject to finance charges (1.5% per month - 18% annually), collection procedures, or other legal processes. A $40.00 fee will be charged for missed appointments and may be charged for cancellations when less than 24 hour notice is provided.
A $20.00 fee will be charged for returned checks.

ASSIGNMENT OF BENEFITS

I, the undersigned, authorize payment of medical benefits to Advance Physical Therapy/Alvin L. Jones, P.T. for any services furnished to me by the care providers of said practice. I assign all rights, benefits and claims I may have under any policy of insurance (major medical, liability, worker's compensation, and any other) and the proceeds from any claim that I may have. *This assignment authorizes direct payment to Advance Physical Therapy/Alvin L. Jones, P.T.*

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I understand that I am responsible for my deductible and any co-payments and non-covered services or supplies. In the event that my account becomes delinquent, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of debt. I have read and understand the billing policies of Advance Physical Therapy.

Patient/Responsible Party Signature_____**Date**_____

Printed Name_____

ADVANCE PHYSICAL THERAPY

RECORD OF DISCLOSURES

The health insurance portability and accountability act (HIPAA) gives patients the right to request restrictions on uses and disclosures of their protected health information (PHI). Patients are also provided the right to request confidential communications or that a communication of PHI may be made by alternative ways, such as sending correspondence to a designated location. Advance physical therapy (apt) will take reasonable steps to limit the use or disclosure of phi to the minimum required to accomplish the intended purpose.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

***NOTE: "MESSAGE"* MAY INCLUDE PRACTICE NAME, APPOINTMENT INFORMATION, OR OTHER SPECIFIC REASON FOR CALL (e.g. BILLING INFORMATION).**

_____**HOME/CELL PHONE**

_____OKAY TO LEAVE ***MESSAGE*** ON MACHINE/VOICE MAIL

_____OKAY TO LEAVE ***MESSAGE*** WITH LISTED PARTIES

_____LEAVE CALL BACK NUMBER ONLY

_____**WORK PHONE**

_____OKAY TO LEAVE ***MESSAGE*** ON MACHINE/VOICE MAIL

_____OKAY TO LEAVE ***MESSAGE*** WITH LISTED PARTIES

_____LEAVE CALL BACK NUMBER ONLY

_____**WRITTEN COMMUNICATION** *(Monthly billing statements will be sent to the address of record.)*

_____OKAY TO HOME ADDRESS – NO RESTRICTIONS

_____OKAY TO MAIL TO HOME IF NO MEDICAL INFORMATION INDICATED

_____OKAY TO MAIL TO OFFICE/WORK ADDRESS

_____OKAY TO FAX TO THIS NUMBER_____

PLEASE LIST ANYONE TO WHOM RELEASE OF INFORMATION REGARDING YOUR CARE AND/OR BILLING IS AUTHORIZED. PLEASE SPECIFY TYPE OF RELEASE BEING AUTHORIZED BY CHECKING THE APPROPRIATE BOX(ES).

(NOTE: *YOUR REFERRING DOCTOR AND INSURANCE CARRIER WILL BE PROVIDED INFORMATION AS REQUESTED AND AS ALLOWED BY LAW. AS SUCH, THEY NEED NOT BE LISTED.)*

NAME	RELATION	MEDICAL√	BILLING √	APPOINTMENT√

I hereby give consent to APT, and all health care providers furnishing care with APT, to use and disclose my PHI for the purposes of treatment, payment, and other health care operations for my case. I understand that I have the right to cancel this consent for the release of information at any time. I understand that said cancellation must be done in writing and will commence upon the date of signed cancellation. I understand that I have the right to request restriction on the usage and disclosure of my PHI for the purposes of treatment, payment or other health care operations. I understand that a photocopy or fax copy of this consent shall be considered effective and valid as the original.

I have been provided the opportunity to review the Notice of Privacy Practices. I understand that my signature authorizes APT to disclose information as directed above and according to HIPAA regulations and/or as deemed necessary by law.

PATIENT SIGNATURE_____ **DATE**_____

PRINTED NAME_____

Consent for Use and/or Disclosure of Images, Videos, Written or Verbal Testimonials

(1) Patient's Printed Name:

_____
Last First Initial or Other

(2) ADVANCE PHYSICAL THERAPY will only disclose the protected health information you permit in relation to photographs, videos, and or testimonials (PHI)

Check the boxes listed below to which you agree and acknowledge the understanding of:

- ☐ Photographs that identify me
- ☐ Videos that identify me
- ☐ Testimonials that I have voluntarily made and given to **ADVANCE PHYSICAL THERAPY** or one if its employees

Check as many items as you agree to:

- ☐ The items I have checked above may be used for any ethical and moral purpose in blogs and other social media
- ☐ The items I have checked may be used for:
  - ☐ Marketing
  - ☐ Professional education
  - ☐ General consumer education
- ☐ I have been informed that I can revoke this consent at any time and **ADVANCE PHYSICAL THERAPY** will discontinue further use or disclosure at that time
- ☐ I realize that if any information has been posted on the internet that **ADVANCE PHYSICAL THERAPY** cannot control how my photographs, videos, or testimonials are used by others
- ☐ I realize that the above items cannot be restricted from use/disclosure for treatment, payment, or operations

(3) Check <u>only</u> one box indicating how long **ADVANCE PHYSICAL THERAPY** can use this consent:

- ☐ Disclose my information indefinitely (as long as ADVANCE PHYSICAL THERAPY has custody of my files)
- ☐ Disclose my PHI for the following period beginning_/__/_____and ending ___/___/_____

_____
Signature of Patient Date

You May Refuse to Sign this Consent

9362 W. Overland Rd. • Boise, Idaho 83709 • (208)672-8144 • Fax (208)672-8145
www.aptorthosports.com • aptboise@aol.com

NOTE: The therapist may recommend that you receive certain supplies (support pillows, self-help books, straps, etc.) that will assist with your rehabilitation. Supplies are not a covered benefit of most insurance policies. This form will be utilized in such case. Please review this form and sign here to indicate that you understand you will be responsible for payment under certain circumstances. We will advise you again and ask you to complete this form when such time arises.

I. Signature:	J. Date:

**** *Office Use Only* ****

NOTICE OF SUPPLY BILLING PROCEDURES

NAME:_____

INSURANCE:_____ **ID #:**_____

DATE	ITEM(S) RECEIVED	COST

WHAT YOU NEED TO DO NOW:

- The purpose of this form is to help you make an informed decision about whether or not you want to receive the item(s) or services, knowing that you might have to pay for the item(s) yourself. Before you make a decision about your options, you should read this entire notice carefully.
- Ask us any questions that you may have after you finish reading. Ask us to explain, if you don't understand why insurance probably won't pay. Ask us how much these item or services will cost you.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1. YES -** I want the item(s) or services listed above. I understand that my insurance may not pay for these item(s) or services. I understand that I will be responsible for payment in full. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If insurance denies payment, I agree to be personally and fully responsible for payment.
☐ **OPTION 2. NO -** I have decided not to receive these item(s) or services. I understand that you will not be able to submit a claim to my insurance carrier and that I will not be able to appeal your opinion that my carrier will not pay.

This notice gives our opinion, not an official INSURANCE decision. Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance carrier, your health information on this form may be shared with them. Your health information will be kept confidential by your insurance carrier.