Advance Physical Therapy

Last Name:_____ First:_____ M:_____

DOB:_____ Age:_____ Social Security#:_____

Circle: Male/ Female circle: Student/ Minor/ Married/ Single/ Widowed

Mailing address:_____

_____

Home#_____ Cell#_____ Work#_____

Place of Employment/ School:_____

Emergency Contact:_____Phone:_____

Primary Insurance (Please provide copy of your card)_____

Secondary Insurance_____

If patient is a minor: Mothers Name:_____Cell#_____

Fathers Name:_____Cell#_____

Is this visit related to a job injury?_____

Is this visit related to a school accident?_____

Is this visit related to an auto accident?_____

Please provide any attorney information_____

Referring Doctor:_____

Have you received any type of Home Health from Mid Delta Home Health, Continue Care, Sta-Home Health, Delta Community Home Health, Community Health Needs, North Sunflower Medical Center Home Health or any other Home Health Agency in the past 3 months? Yes/No

Have you received Outpatient Physical Therapy Services in the past? Yes/No

If yes, When: _____ Where: _____

Why are you being referred for Physical Therapy? _____

List any medications you are currently taking: _____
_____
_____
_____

List any operations or surgeries you have had: _____
_____
_____

Do you have any allergies or reactions to medications/drugs? Yes/No
If yes, please list here: _____

Are you currently under the care of a physician, other than the one who referred you to our clinic: Yes/No
If yes, please name here: _____

Are you pregnant: Yes/No
If yes, how many weeks? _____

Please circle any of the following that may apply to you:

AIDS	Drug Abuse/Use	Lupus
Allergies	Emphysema	Metal/Foreign Implants
Anemia	Epilepsy	Motor Vehicle Accident
Arthritis	Fainting	Pacemaker
Asthma	Fractures	Psychiatric Treatment
Back Trouble	Head Aches	Seizures
Bleeding Disease	Heart Attack	Stroke
Bronchitis	Heart Disease	Thyroid Disease
Cancer	Heart Murmur	High Blood Pressure
Chest Pain	Hepatitis	
Circulatory/PVD	Herpes	Other:
Congenital Heart Defect	Joint/Bone Problems	_____
Congestive Heart Failure	Kidney Disease	_____
Diabetes	Liver Disease	

Patient Signature: _____

Date: _____

Advance Physical Therapy
810 E. Sunflower Rd, Suite 150
Cleveland, MS 38732

Billing Information

In an effort to provide you with the highest quality of care possible, we feel that it is important that you understand how you will be billed for the services that you receive.

In accordance with the law, all insurance companies are billed the same amount for the same service. However, our clinic has individual contracts with "PPO Networks" that allow us to charge an allowed fee for services provided. You will not be held responsible for any amount over that contracted amount. You will be billed for these services after we receive payment/denial from your insurance company. Payment plans are available to help you pay your balance in a timely manner. If your bill becomes delinquent without any effort of payment, your account will be placed with our collection/legal department for payment.

Informed Consent

I authorize Advance Physical Therapy to perform treatment to me/my child in accordance to my physician's orders. I understand that I can refuse treatment and that an explanation of possible consequences resulting in the refusal of treatment will be provided to me, and my physician will be notified. I also acknowledge that I have received a copy of the Patient's Bill of Rights by this facility, and understand my rights therein.

I request that my payment of my Medicare/Insurance Company benefits be made to Advance Physical Therapy for any services to me. (If you have Medicare, regulations pertaining to the assignment of benefits apply). I authorize the release of my medical records/information in order for the clinic to be reimbursed for services rendered to me. I permit this copy of this authorization to be used in place of the original. I understand that it is mandatory to notify the healthcare provider (Advance Physical Therapy) of any other party that may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information.)

Signature of Patient or Legal Guardian _____ Date _____

Witness _____ Date _____

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Advance Physical Therapy** to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of our practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

I have reviewed the Notice of Privacy Practices and give my permission to **Advance Physical Therapy** for the use and disclosure of my health information in accordance with it.

Patient Signature _____ Date _____

Signature of Patient Representative _____ Relationship to Patient _____