advanced physical therapy SOLUTIONS

making movement better.™

Welcome to Advanced Physical Therapy Solutions!

Please fill out and return each of the following documents that are attached. Many of these forms are required by insurance carriers and having them already filled out will help expedite the evaluation process on your first day.

We look forward to meeting you and helping you “make movement better”!

CONSENT TO THERAPY AND AUTHORIZATION TO TREAT

1) I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist and support staff employed by Advanced Physical Therapy Solutions, LLC (APTS). I understand that the physical therapist will explain the purpose and procedures they will perform. I will also be informed as to the expected benefits or potential complications as a result of participation. Initial _____

2) I realize I have the right to refuse any treatment or procedures to the extent permitted by law. I understand the delivery of healthcare is not an exact science, so no guarantees or warranties can be made to me regarding the result of any treatments at this facility. I understand the information from medical records kept by this facility may be used for educational, administrative and/or facility approved purposes and my personal identity will not be revealed. Initial _____

3) I authorize payment of medical benefits to Advanced Physical Therapy Solutions, LLC. for services rendered. I understand that APTS will make reasonable effort to collect insurance proceeds by submitting billing information for processing. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.Initial _____

4) I understand that copayments/co-insurances are due at the time of service. I understand that APTS does have a payment plan if I need to extend my payments over a longer period of time. Initial _____

5) I understand that if I do not see my physical therapist for **two** weeks or miss **two** consecutive appointments, the physical therapist may discharge my case. I have read and understand that APTS has a **cancellation policy** that requires a minimum of 24-hour notice to cancel an appointment or **I will be charged a fee of $75**. This fee is due before the next scheduled treatment appointment. Initial _____

6) I authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. Initial _____

7) Worker's Compensation-I hereby authorize my case manager to receive my records related to my work injury. Initial _____

8) I understand that my doctor will automatically receive a copy of my records at no charge; and that if I or anyone else as designated below requests and obtains a copy of my medical records, I will be responsible for a **$25 fee per set** of records provided. Initial _____.

PLEASE COMPLETE BACK SIDE →

Acknowledgment of the "**Notice of Privacy Practices**".
Release of medical information request

I have been given the opportunity to review Advanced Physical Therapy Solutions' "**Notice of Privacy Practices**". This document contains a description of the uses and disclosures of my protected healthcare information and my rights regarding such information. APTS displays the "**Notice of Privacy Practices**" in its clinic reception area. I understand that APTS has the right to change its "**Notice of Privacy Practices**" and that if changes are made, a revised copy of the notice will be posted in the reception area. I also understand that I have if I have any questions or wish to receive copies of the current "**Notice of Privacy Practices**", I may request that document from the front desk or access it from the APTS website. I permit a copy of this form to be used in lieu of the original.
Initial _____

I authorize APTS, LLC (APTS) to obtain a release health information from/to the following:

_____

Name of person or Name of facility Name of person or Name of facility

If you are the representative for the patient, check the scope of your authority to act on the patient's behalf:
☐ Power of Attorney ☐Guardian ☐ Parent ☐ Other

I have read and fully understand the above general consent form. Any questions have been answered to my satisfaction. By signing this form, I am acknowledging my understanding of the "notice of privacy practices" and authorizing persons or institutions listed on the information release to receive or not receive my health information.

_____

Signature of Patient or Parent Date

_____

Witness (APTS employee) Date

ATTENDANCE POLICY

Your appointments will be scheduled according the physical therapist's prescribed plan of care that will be agreed upon by you following your evaluation. It is important that you adhere to that plan to achieve the best outcomes in physical therapy.

If you have a conflict arise and cannot keep your scheduled appointment, you should contact us as soon as possible. **We REQUIRE 24-hour notice to cancel your appointment. No shows are unacceptable**. You may leave a message on the voicemail if calling after hours.

If you do not contact us within 24 hours of your appointment, you will be charged a $75 late cancellation/no-show fee. This cannot be billed to your insurance and will be your responsibility.

In the event of 2 consecutive no-shows or cancellations, you may be discharged from our care, and your physician will be notified.

FRAGRANCE POLICY

We have patients and staff who suffer from respiratory conditions and are highly sensitive to odors and fragrances such as perfume, cologne, scented lotion, and cigarettes. Please refrain from use of these products prior to your physical therapy visits.

I understand and agree to the policies above.

_____ _____

Signature Date

Physical Therapy Medical Screening Questionnaire

Name: _____ Height: _____ Weight: _____

Occupation: _____

Reason for your physical therapy visit: _____

How did your symptoms start? (i.e. fall, accident, unknown) _____

When did your symptoms start? _____

Tests/Imaging: _____ Results (if known): _____

How intense are your symptoms when they occur? **(circle one)**

No pain Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Since onset, are your symptoms **(circle one)**: Getting better Staying the Same Getting Worse

What makes your symptoms worse? _____

What makes your symptoms better? _____

What activities are difficult because of your symptoms? **(circle all that apply)**

Reaching	Bending	Squatting	Upper body dressing
Lifting	Sitting	Running	Lower body dressing
Carrying	Rising	Jumping	Household chores
Bathing	Standing	Working	Other: _____
Grooming	Walking	Sports activities	Other: _____

How many falls have you had in the last year? _____ Were you injured? _____

Please **circle** any of the conditions below that you currently have or have had in the past (or attach list).

Allergies: Latex/Adhesives	Diabetes	Psoriatic Arthritis
Acid Reflux	Fibromyalgia	Rheumatoid Arthritis
Anemia	Heart Attack	Scoliosis
Anxiety	Hernia	Seizures
Asthma	High Blood Pressure	Stroke
Blood Clots	Migraines	Thyroid Disease
Cancer: _____	Multiple Sclerosis	Urinary Incontinence
Congestive Heart Failure	Osteoarthritis	Vertigo
COPD	Osteoporosis	Visual Impairment: _____
Currently Pregnant	Pacemaker	Other: _____
Depression	Parkinson's Disease	Other:_____

PLEASE COMPLETE BACK SIDE
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Please list any surgeries you have had (or attach list).

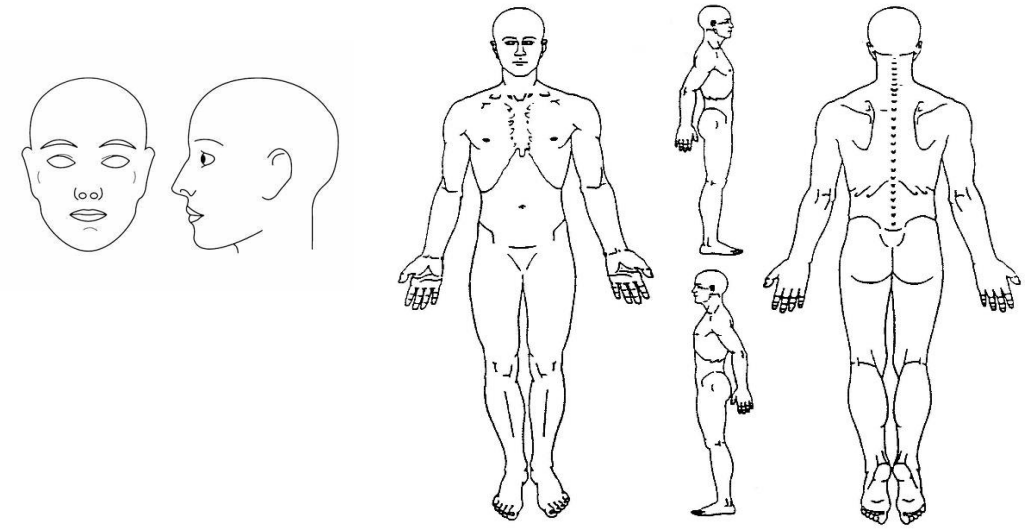
_____ Date _____ _____Date_____
_____ Date _____ _____Date_____
_____ Date _____ _____Date_____

Please list all the medications you take (or attach list).

_____ Dosage _____ Frequency _____ Route (ie. Oral/injection) _____
_____ Dosage _____ Frequency _____ Route (ie. Oral/injection) _____
_____ Dosage _____ Frequency _____ Route (ie. Oral/injection) _____
_____ Dosage _____ Frequency _____ Route (ie. Oral/injection) _____
_____ Dosage _____ Frequency _____ Route (ie. Oral/injection) _____

Please indicate on the body chart where your symptoms are located.

→→→ Burning, Sharp, Shooting **XXX** Numbness, Tingling **OOO** Dull, aching **////** Throbbing



RED FLAGS FOR THERAPIST USE ONLY:

CAD	**CA**	**Cauda Equina**	**Fracture**	**Myelopathy**
Dizziness	>50	Saddle anesthesia	>65yo	>45yo
Dysphagia	Prior Hx	Urinary retention	Trauma	Hoffmans
Dysarthria	1st relative	Fecal incontinence	Tender over SPs	Babinski
Diplopia	Night pain	Progressive LE sx	Corticosteroid use	Inverted supinator
Drop Attack	Unexplained wt loss	Ataxia	Supine intolerance	Gait deviation
Nystagmus	Non-mechanical	Sexual dysfunction		
Nausea		Hyporeflexia		
Periorbital numbness				
Ataxia				

I have reviewed contents with the patient. _____Date _____

GERIATRIC DEPRESSION SCALE (≧18 YEARS OLD)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel that you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive right now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Score 1 point for every bold item _____
≧6 = recommendations for referral