

Please Print

LAST NAME _____ FIRST _____ MI _____

DATE OF BIRTH: _____ SEX: _____ SOCIAL SECURITY #: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ WORK #: _____ CELL #: _____

OUT OF STATE PHONE (IF APPLICABLE): _____

OUT OF STATE ADDRESS (IF APP.): _____

MARITAL STATUS: _____ EMPLOYER NAME: _____ PHONE #: _____

EMAIL ADDRESS: _____ MAY WE USE YOUR EMAIL ADDRESS? _____

REFERRING PHYSICIAN INFORMATION

PHYSICIAN NAME: _____ PHONE: _____

REASON FOR TODAY'S VISIT

DESCRIBE INJURY/ACCIDENT/ILLNESS: _____ INDICATE DATE OF ONSET: _____

HOW DID YOU HEAR ABOUT US? (Example physician, friend, insurance, advertisement): _____

MAY WE USE YOUR NAME IN THANKING THIS PERSON? YES _____ NO _____

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

IDENTIFICATION #: _____ GROUP #: _____

POLICYHOLDER: _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME: _____

IDENTIFICATION #: _____ GROUP #: _____

POLICYHOLDER: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

IN CASE OF EMERGENCY CALL

NAME: _____ PHONE #: _____

RELATIONSHIP TO PATIENT: _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO ADVANCED PHYSICAL THERAPY & REHAB OF LEE, INC. IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELIQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT OWING AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF ADVANCED PHYSICAL THERAPY & REHAB OF LEE, INC. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPT FOR ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE:	TODAY'S DATE:

PATIENT INFORMATION CONSENT FORM (HIPAA)

I have read and fully understand Advanced Physical Therapy & Rehab 's Notice of Information Practices. I understand that Advanced Physical Therapy & Rehab may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Advanced Physical Therapy & Rehab will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Advanced Physical Therapy & Rehab 's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature

Date

PATIENT RECORD OF DISCLOSURES

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Health care entities must keep records of protected health information disclosures. Advanced PT maintains records of such disclosures in patient chart.

I wish to be contacted in the following manner:

___ Home Telephone/Cell Telephone _____

___ Okay to leave a message with detailed information

___ Leave message with call-back number only

___ Work Telephone _____

___ Okay to leave a message with detailed information

___ Leave message with call-back number only.

___ Written communication

___ Okay to mail to my home address

___ Okay to mail to my office/work address

___ Okay to fax to this number.

Signature

Date

**ADVANCED PHYSICAL THERAPY & REHAB
MEDICAL HISTORY FORM**

NAME: _____ DATE: _____

AGE: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

CHECK THE BOX BELOW IF YOU HAVE OR CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS,
SURGERIES, OR DISEASES:

- | | |
|--|--|
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> LEGALLY BLIND |
| <input type="checkbox"/> CANCER: TYPE?
WHEN? | <input type="checkbox"/> HARD OF HEARING: Do you
Wear hearing aids? |
| <input type="checkbox"/> HEART ATTACKS: when? | <input type="checkbox"/> STROKE: when? |
| <input type="checkbox"/> HEART BYPASS SURGERY: | <input type="checkbox"/> DIABETES: how long? |
| <input type="checkbox"/> HIGH BLOOD PRESSURE:
Is it controlled? | <input type="checkbox"/> SEIZURES: how often? |
| <input type="checkbox"/> CHEST PAIN: how often? | <input type="checkbox"/> ALLERGIC REACTIONS: to
what? |
| <input type="checkbox"/> HIP REPLACEMENT: when?
Left or Right? | <input type="checkbox"/> INFECTIONS: when?
Type? |
| <input type="checkbox"/> URINARY INCONTINENCE: | <input type="checkbox"/> LOSS OF SPOUSE: when? |
| <input type="checkbox"/> BOWEL INCONTINENCE: | <input type="checkbox"/> DEPRESSION: when? |
| <input type="checkbox"/> FALLS OR LOSS OF BALANCE:
How many times in the last 6 months? | <input type="checkbox"/> ANXIETY, STRESS OR FEAR:
When? |
| <input type="checkbox"/> LONELINESS: when? | |
| <input type="checkbox"/> EMOTIONAL DISTRESS: | |
| <input type="checkbox"/> FAMILY CONCERNS: | |
| <input type="checkbox"/> SEXUAL CONCERNS: | |

PLEASE DESCRIBE ANY OTHER DISEASES, SURGERIES, CONDITIONS OR HOSPITALIZATIONS
THAT YOU HAVE HAD:
