ADVANCED PHYSICAL THERAPY & Rehabilitation

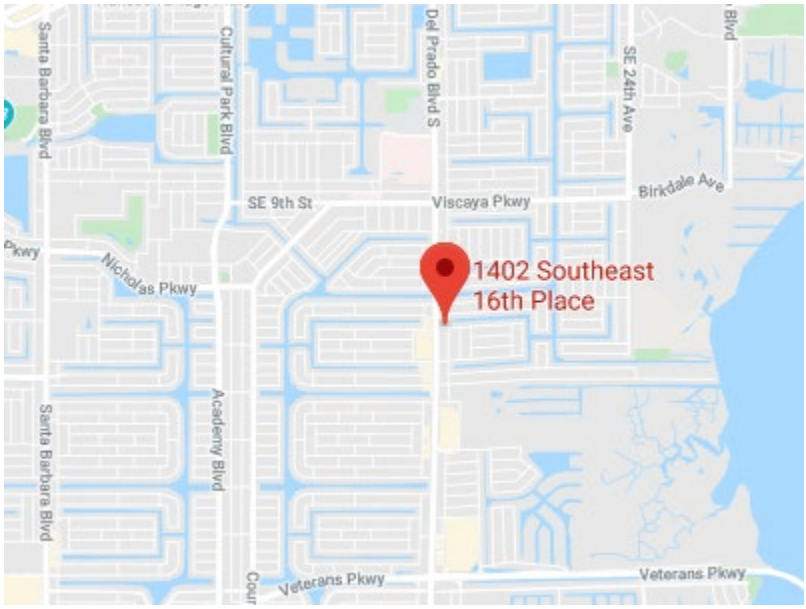
One-on-one care. One-of-a-kind experience.

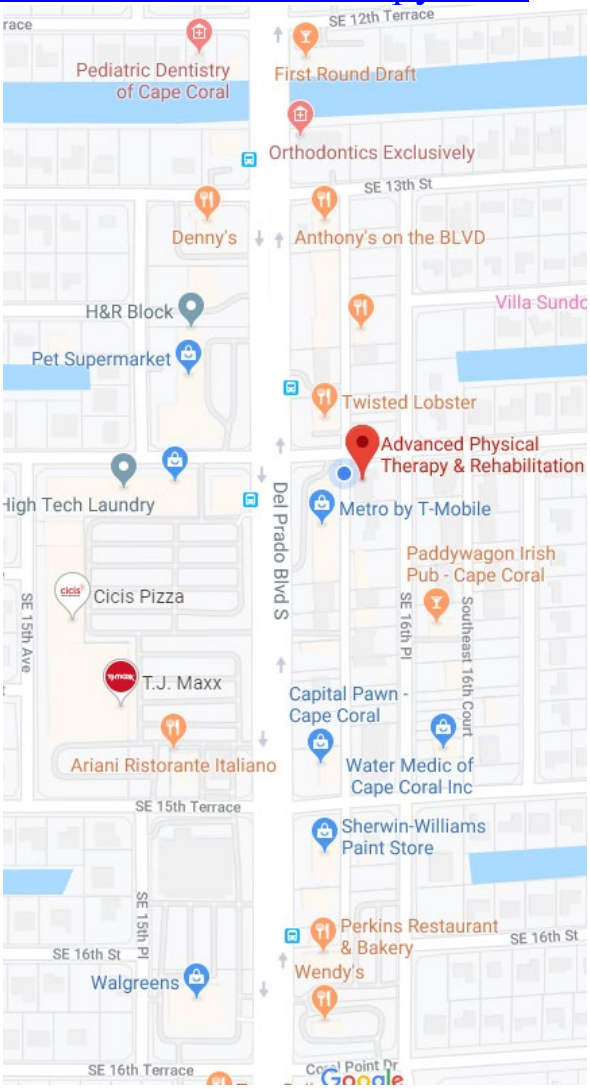
www.YourBestTherapy.com

Welcome Aboard and Thank you!

How do I get there?

www.YourBestTherapy.com





Advanced Physical Therapy in Cape Coral is located at 1402 SE 16th place near the 24hr Walmart on Del Prado and across the side street, SE 14th Street, from the "Twisted Lobster" restaurant.

Take Del Prado to SE 14th Street, then turn right on SE 16th Place. We are on the corner intersection of these streets.

TIP: If you have a smartphone (Siri, Google, Android), use the Microphone symbol to say, "Navigate to Advanced Physical Therapy Cape Coral" for GPS step-by-step directions.

Use Smartphone GPS to "Navigate to Advanced Physical Therapy of Cape Coral"
www.YourBestTherapy.com – click Add to contacts on address into your phone
Call 239-772-2363 for our Lovely office staff to assist you!

6314 Whiskey Creek Drive / Fort Myers, FL 33919 / Tel: 239.432.0556 / Fax: 239.432.9727
1402 SE 16th Place / Cape Coral, FL 33990 / Tel: 239.772.2363 / Fax: 239.772.2365

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What to Bring

Arrive 20 minutes early to your appointment the first time for your Evaluation. There is paperwork to fill out that is required by insurance and past medical history forms. Wear comfortable clothing and tennis shoes if possible.

- Insurance Cards to copy into our records
- Photo ID to copy and secure your medical records
- Medications list to copy into records
- Any records pertaining to your case, don't worry we can obtain records from physicians
- Physician's prescription if not already sent to our office

What to Expect! It's not Scary!

Your first visit is your Initial Evaluation. This is the time you and your therapist talk about your functional problems and issues. The therapist collects many objective measurements and data during this visit to get a clear picture of your deficits. Your therapist will develop a plan of care to help you achieve your goals and guide you through your care. The therapist will create an Evaluation Report that is sent to the physician for comparison at your Progress Evaluation usually 4 weeks later.

Physical Therapy usually is a process of 2-3 appointments a week for 4 weeks. Physical Therapy can include therapeutic exercises, stretching, manual therapy / massage, endurance/conditioning, modalities, etc. Your progress is documented from the Initial Evaluation to the Progress Evaluation like a report card that your physician receives to assess your progress.

At Advanced Physical Therapy and Rehabilitation we truly perform one-on-one care. Many facilities see 2,3,4 patients at the same time. YOU are scheduled with your therapist individually in a 45 minute slot and your appointment can be 45 minutes to an hour.

PLEASE BE CONSISTENT WITH YOUR APPOINTMENTS. YOUR SCHEDULED TIME IS WITH YOU AND THE THERAPIST. To continue to give one-on-one care we need clients to come to their appointments and to make sure you are progressing with your care per the physician orders and your goals.

BEST OF CAPE CORAL News-Press.

- VOTED "BEST OF" 7 years in a row
- Genuine caring the old fashion way
- Individual care, not a gym

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ADVANCED PHYSICAL THERAPY & REHAB Date: _____

PERSONAL INFO: (Please Print)

Home Health in the last 6 months? Yes_____ No_____

Is there/ Has been any Attorney Involvement? Yes_____ No_____

LAST NAME_____ FIRST_____MI_____

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

HOME ADDRESS:_____ CITY:_____

STATE:_____ ZIP CODE:_____ EMAIL ADDRESS (if applicable): _____

PHONE #:_____ WORK #:_____CELL #:_____

OUT OF STATE PHONE (IF APPLICABLE):_____

OUT OF STATE ADDRESS (IF APP.):_____

MARITAL STATUS:_____ EMPLOYER NAME:_____PHONE #:_____

REFERRING PHYSICIAN INFORMATION:

PHYSICIAN NAME:_____ PHONE:_____

REASON FOR TODAY'S VISIT:

DESCRIBE INJURY/ACCIDENT/ILLNESS:_____

INDICATE DATE OF ONSET/ACCIDENT/INJURY:_____

HOW DID YOU HEAR ABOUT US? **(Please circle all that apply)**: Insurance Co. / Newspaper Ad / Radio Ad / Phone Book / Internet Search / Brochure / Physician / Friend / Other: _____

PRIMARY INSURANCE COMPANY INFORMATION:

PRIMARY INSURANCE COMPANY NAME: _____ ID#_____

GROUP # _____POLICYHOLDER:_____DATE OF BIRTH_____

SOCIAL SECURITY NUMBER OF POLICYHOLER (if other than patient):_____

RELATIONSHIP TO PATIENT:_____ EMPLOYER:_____

SECONDARY INSURANCE COMPANY INFORMATION:

PRIMARY INSURANCE COMPANY NAME: _____ ID#_____

GROUP # _____POLICYHOLDER:_____DATE OF BIRTH_____

SOCIAL SECURITY NUMBER OF POLICYHOLER (if other than patient):_____

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.

HAVE YOU HAD ANY OTHER PHYSICAL, SPEECH, RESPIRTORY ,OCCUPATIONAL, MASSAGE THERAPY, OR CHIROPRACTIC SERVICES THIS YEAR (YES / NO) IF YES HOW MANY VISITS _____?

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.

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.

CONTACT POLICY

Advanced Physical Therapy & Rehab may contact you at the telephone numbers you have provided to us and may leave detailed messages for you. Correspondence may also be mailed to the address you have provided to us. If this is NOT acceptable, please indicate below how we may contact you:

CANCELLATION POLICY

Cancellations/No Shows are subject to a $30 fee without 24 hours notice. To continue providing personalized care, we need your commitment to appointments. Thank you for your cooperation!

Please sign below to acknowledge that you have read, understand and agree to all the aforementioned statements.

_____ _____

(Signature) (Date)

ADVANCED PHYSICAL THERAPY & REHAB

MEDICAL HISTORY FORM

NAME:_____ DATE:_____

AGE:_____ HEIGHT:_____ WEIGHT:_____

LIST **ALL MEDICATIONS** YOU ARE CURRENTLY TAKING:_____

_____

_____

_____

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

( ) PACEMAKER
( ) CANCER: TYPE?
WHEN?
( ) HEART ATTACKS: when?
( ) HEART BYPASS SURGERY:
( ) HIGH BLOOD PRESSURE:
Is it controlled?
( )CHEST PAIN: how often?

( ) HIP REPLACEMENT: when?
Left or Right?
( ) URINARY INCONTINENCE:
( ) BOWEL INCONTINENCE:
( ) FALLS OR LOSS OF BALANCE:
How many times in the last 6 months?
( ) LONELINESS: when?
( ) EMOTIONAL DISTRESS:
( ) FAMILY CONCERNS:
( ) SEXUAL CONCERNS:

( ) LEGALLY BLIND
( ) HARD OF HEARING: Do you
Wear hearing aids?
( ) STROKE: when?
( ) DIABETES: how long?
( ) SEIZURES: how often?

( ) ALLERGIC REACTIONS: to
what?
( ) INFECTIONS: when?
Type?
( ) LOSS OF SPOUSE: when?
( ) DEPRESSION: when?
( ) ANXIETY, STRESS OR FEAR:
When?

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

_____

_____

_____

_____

_____

Advanced Physical Therapy & Rehab

Primary Payer Questionnaire

The questions below are for **Beneficiaries age 65 or older**, and are used to comply with Medicare Regulation 42 CFR 489.20 (F).

1) Are you **currently** working full or part time? Yes No

2) If married is your spouse **currently** working full or part time? Yes No

3) Do you have group health plan coverage based on your own, or a spouse's **current** employment? Yes No
If YES, please provide the following information:
Name of Insured_____
Relationship to patient_____
Name of Employer _____
Name of Carrier_____
Group/Policy#_____

4) Are you receiving Black Lung (BL) Benefits? Yes No

5) Is this service for treatment work related? Yes No
If YES, please provide the following information:
Name of Insured_____
Name of Employer_____
Date of Injury_____
Policy/Claim#_____

6) Is this service for treatment related to an auto injury? Yes No
If YES, please provide the following information:
Name of Insurer_____
Name of Policyholder_____
Date of injury_____
Claim Number_____

7) Are benefits for services being submitted to any other party for reimbursement consideration? Yes No

8) Are you currently enrolled in hospice or home health? Yes No

Medicare Authorization – Patient Release and Authorization (all Medicare Patients)

1) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.
2) I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

++NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.++++++++++++++++++++

Signature of Patient Date

Printed Name of Patient Witness

Advanced Physical Therapy & Rehab

Authorization to Release Medical Records

Patient Name: _____, DOB: _____

TO: Dr. _____
(Referring Physician's Name)

I hereby authorize and request you to release to A BRIEF history in your possession concerning my illness and/or treatment to:

Advanced Physical Therapy & Rehab of Cape Coral
1402 SE 16th Place
Cape Coral, FL 33990

Signature: _____, Date: _____

Witness: _____

Cape Coral, Florida