

Advance Therapy



Aquatic & Wellness Center

Your Road To Wellness

Ph (979)774-9958 Fax (979)774-9978

New Patient Information Sheet

Please Print Legibly and complete all Information

Patient's Name: _____ Date of Birth : _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: (____) _____ Cell: (____) _____

Work: (____) _____

*Check preferred Contact Call Text Email: _____

Gender: **Male/Female** SSN: _____ Primary Care Doctor: _____

Employer: _____ Occupation: _____

Is this a school/sport-related injury? **Yes No** If yes, day of injury: _____ School: _____

Is this injury a result of an automobile accident/LOP? **Yes No** If yes, Attorney/Firm _____

Phone # _____ PIP _____ Claim # _____

Responsible party for this account (if different from patient): Name _____ Phone: _____

Primary Insurance Company _____ Policy Number: _____

Policyholder's Name: _____ Group Number _____

Policyholder's SSN: _____ **Policyholder's DOB:** _____

Is this a Medicare replacement Product? **YES NO**

Relationship of patient to the policyholder: SELF SPOUSE DEPENDENT

Secondary Insurance Company _____ Policy Number: _____

Policyholder's Name: _____ Group Number: _____

Policyholder's SSN: _____ **Policyholder's DOB:** _____

Relationship of patient to the policyholder: SELF SPOUSE DEPENDENT

Medicare Only

Medicare Only

If you do not have a secondary insurance carrier you must sign the statement below.

This is to certify that I, _____ do not have a Secondary Insurance Policy as of the

_____ day of _____, 20_____.

Are you in **HOME HEALTH /Skilled Nursing Facility**? **Yes No** If yes, you must be discharged by the agency before being treated in this clinic. Medicare will not pay for both services. **Initial Here** _____

Release of information and Assignment of Benefits: I understand that as a part of my Healthcare Individually Identifiable Health Information will be recorded. I hereby authorize this healthcare provider and any of its employees to furnish to my insurance company any and all information necessary to process my health insurance claims. I assign and transfer all rights and benefits payable for health care rendered. A photocopy of the rendition of services by the provider
Consent for treatment: I, the undersigned, am the patient (or the patient's legal representative) and do hereby voluntarily consent to and authorize Advance Therapy, P.C. and a Texas Professional corporation, to administer treatment as per the physician's orders.

Signature of patient/guardian _____

Date: _____



Patient Medical History

Patient name: _____ Date _____

Chief Complaint(s) _____

Surgeries in the past year: _____

Height: _____ **Weight:** _____

Current Medications: If you have a list already printed out please present to front desk so a copy can be made.

Conditions	Yes	No	
Alzheimer's			
Cardiovascular Disease			
Cauda Equine Syndrome			
Cerebral Vascular Accident			
Current Infection			
Diabetes Type 1			
Diabetes Type 2			
Fibromyalgia			
Fracture			
High Blood Pressure			

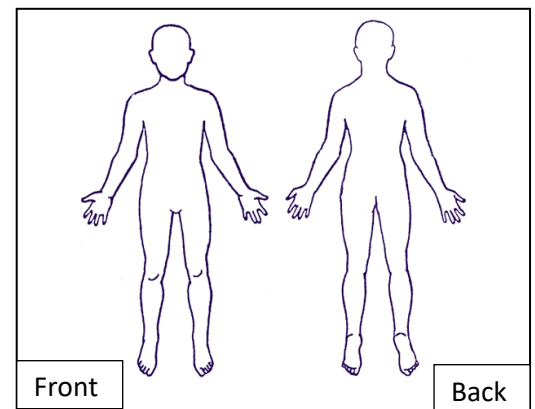
Conditions	Yes	No	
Cancer			
Huntington's			
Immunosuppression			
Lupus			
Muscular Dystrophy			
Obesity			
Osteoarthritis			
Parkinson's			
Rheumatoid Arthritis			
Traumatic Brain Injury			

Pain/Symptoms

Are you in pain?



Pain Best _____/10
Worst _____/10
Current _____/10



Describe you symptoms using the follow symbols:

- (+) Numb/Tingling (#) Ache
- (B) Burning (X) Sharp

Have you had 2 or more falls in the past year? (Yes) or (No)

Have you had a fall in the past year that resulted in an injury? (Yes) or (No)



Patient Name: _____

Patient Privacy Notice (HIPAA Form)

This Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. Protected health information includes any information maintained by Advance Therapy that could identify you and your health condition.

You have the right to review our notice before signing this consent. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction. But if we do, we are bound by our agreement. We will not use health information for directory purposes. I understand that a source of information like my diagnosis and physical therapy treatments will be applied to my bill. I also, understand that if I have a third-party payer they can verify that my services billed were actually provided by Advance Therapy.

Each time you begin physical therapy treatment at our clinic, a record is made of this encounter. Typically, this record contains medical information from your referring physician, the prescription and other information that you provide to us. In this "Notice of Health Information Practices," we shall refer to the information contained in your records as your "protected health information" (PHI) as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent

Signature of patient (or Parent/Guardian)

Date

Office use only

Witness: _____ Date: _____

How did you hear about us?

Internet

Doctor

Facebook

Radio

Family/Friend -Who can we thank for this referral: _____

Other: _____



Patient's Name _____

Patient Responsibilities

Insurance

- It is the patient's responsibility to know your insurance benefits and policy requirements for office visits and procedures such as physical therapy.
- It is the patient's responsibility to bring current insurance card(s) and method of payments for each office visit or therapy.
- It is the patient's responsibility to update your insurance information, current address and contact information for our records. Failure to do so will cause the patient to become responsible for all charges
- It is the patient's responsibility to provide a pre-authorization (If required by your insurance) or a letter of medical necessity (if required) from your physician prior to treatment.

I understand the information about Insurance _____ initial

Treatment

- It is the patient's responsibility to inform the front desk and therapist if you are currently being treated at another clinic
- It is the patient's responsibility to provide a current prescription and/or referral prior to treatment
- It is the patient responsibility to inform the front desk/therapist if your treatment is the result of an MVA, school or work related injury
- It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequence of those decisions.
- As a patient of Advance Therapy, you may receive manual physical therapy treatment, including soft tissue mobilization, joint mobilization, and joint manipulation.

I understand the information about treatment _____ initial

Appointments

- It is the patient's responsibility to keep follow-up appointments as scheduled. Failure to show up for appointments can result in a delay in your POC. Your attendance is critical.
- Failure to keep 2 consecutive appointments, no shows and account no longer maintained in good faith status may result in being discharged from our Advance Therapy.
- It is the patient's responsibility to notify our office **24 hours** prior to your scheduled appointment if you are unable to keep your appointment. Failure to do so will result in a **\$25.00** no show/cancellation fee which must be paid prior to scheduling your next appointment.

I understand the information about appointments _____ initial

I have read and understand my responsibilities as a patient. All of my questions have been answered.

Patient Signature

Date