ADVANCE
PHYSICAL THERAPY

NEW PATIENT INFORMATION SHEET

Please Print Legibly and complete all Information

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

*Check preferred Contact: ☐ Call ☐ Text ☐ Email: _____

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: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Policy #: _____

Policyholder's Name: _____ Group #: _____

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 #: _____

Policyholder's Name: _____ Group #: _____

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

Is this a Medicare replacement Product? ☐ Yes ☐ No

Relationship of patient to the policyholder: ☐ Self ☐ Spouse ☐ Dependent

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

ADVANCE
PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: _____

Chief Complaint(s): _____

Surgeries in the Past Year: _____

Height: _____ Weight: _____

CURRENT MEDICATIONS:

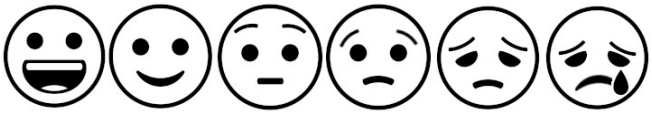
If you have a list already printed out, please present it to the front desk so a copy can be made.

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?

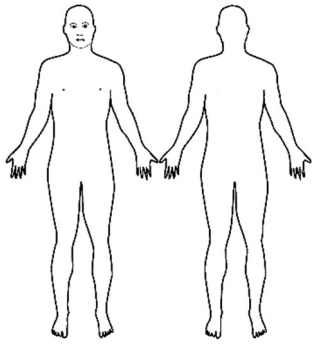


0	1-2	3-4	5-6	6-8	9-10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Best: _____/10 Worst: _____/10 Current: _____/10

Have you had 2 or more falls in the past year? ☐ Y ☐ N

Have you had a fall in the past year that resulted in an injury? ☐ Y ☐ N



Describe your symptoms using following symbols:

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

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE FEEL FREE TO CONTACT ADVANCE PHYSICAL THERAPY'S HIPAA PRIVACY OFFICER

Advance Physical Therapy (APT) is committed to maintaining and protecting the confidentiality of your personal information. This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It will inform you about how we may use and disclose your health information, and the safeguards we have put into place to protect it. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

OUR DUTIES TO YOU REGARDING YOUR PROTECTED HEALTH INFORMATION

"Protected Health Information" is individually identifiable health information expressed in the form of oral, written or electronic communications. This information includes personal identifiers such as your age, address, email address, and other information that relates to your past, present or future health condition and related healthcare services. APT, a healthcare entity, is required by law to:

- Make sure your health information is kept private and secure.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of this Notice currently in effect and we will not use or share your protected health information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.
- Communicate any changes in this Notice to you.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information.

Treatment: We may use and/or disclose your confidential health information to provide you with treatment and/or services. This includes your therapist's recommendation(s), and those of other professionals/paraprofessionals including clerical, administrative and management staff.

Payment: Your protected health information will be used, as needed, to bill and collect payment for treatment and services provided to you. We may share information about a treatment and/or service you may receive to your health insurer or responsible party to receive approval for payment.

Health Care Operations: We may use and disclose health information about you for regular health care operations. The medical staff in this practice will use your health information to assess the care you received

and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality assessment/improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

Disclosures to Business Associates: We may share your protected health information with third-party "business associates" who perform various activities for the practice. The business associates will also be required to protect your health information.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or care in our Practice. These reminders will not identify the purpose of your visit.

Required by Law: We will disclose health information about you when required to do so by federal, state or local laws.

Public Health Activities: We may disclose your protected health information for the following public health activities and purposes:

- To report health information to public health authorities that are authorized by law to receive such information to prevent or control disease, injury or disability;
- To report child abuse or neglect to a government authority that is authorized by law to receive such reports;
- To report information about a product or activity that is regulated by the US Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity;
- To help with product recalls; and
- To alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.

Legal Proceedings: We may release protected health information about you in response to a court or administrative order if you are involved in a lawsuit or dispute. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement: We may release health information if asked to do so by law enforcement officials:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
- In response a death we believe may be the result of criminal conduct.
- In response to potential criminal conduct at the Practice.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Research: Under certain circumstances, we may use and disclose your protected health information for research purposes.

Workers' Compensation: We may release your health information to comply with Workers' Compensation Laws and other similar legally-established programs. The programs provide benefits for work-related illness or injury.

Criminal Activity: Under certain Federal and state laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Government Functions: We may disclose your protected health information to the U.S. Military or to authorized federal or state officials for purposes specified by federal law.

Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We may also disclose protected health information to funeral directors as authorized by law to assist them in carrying out their duties. Protected health information may also be used and disclosed for organ eye and tissue donations if you have previously agreed to organ donation.

Parental Access: Various Texas state laws determine what protected health information can be disclosed to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law and will make disclosures only when necessary.

Individuals Involved in Your Care: Unless you object, we may use or disclose your protected health information to notify or assist in the notification of a family member or personal representative of your location, your general condition, or death. If you are present, you will have the opportunity to object to this type of use or disclosure. If you are unable to decide or if it is an emergency, we may disclose information that is directly relevant to the person's involvement in your healthcare, if we determine that it is in your best interest to do so.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your protected health information. You may make any of the following requests by completing a "HIPAA Patient Rights Request Form" or by submitting a written request to our office.

Right to Inspect and Copy: You have the right to both inspect and obtain a copy of your protected health information for as long as we maintain your health information. If you request paper copies, we may charge you copying and mailing costs. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your

care or the payment for your care. While we consider all requests for restrictions carefully, we are not required to agree to your request.

Right To Request Amendment: If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment as long as the information is kept by or for APT, if we determine the record is inaccurate.

We may deny your request if it is not in the appropriate form or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information kept by or for APT
- Is not part of the information which you would be permitted to inspect or copy
- Is accurate and complete

Right to Request Confidential Communications: You may request that we communicate with you using alternative means or at an alternative location. You may also ask that we mail information to you in a sealed envelope rather than a postcard. While we will consider this request carefully, we are not required to agree to all requests.

Right to Obtain an Accounting of Disclosures: You may ask for a list (accounting) of the times we have shared your health.

Right To Obtain a Copy of this Notice. You have the right to a paper or electronic copy of this Notice. You may request a copy of this Notice at any time. To obtain a copy of this Notice, please contact the office using the contact information below.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this Notice. We reserve the right to make changes to this Notice retroactively effective for protected health information we already have about you as well as any information we receive in the future. If we change the Notice, we will provide each active patient with a new Notice. You may also obtain the latest version of this Notice by calling our office.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with APT's HIPAA Privacy Officer or his/her designee at the address below. No retaliation will occur against you for filing a complaint. All complaints must be submitted in writing. You may also file complaints with the Secretary of the US Department of Health and Human Services.

Advance Physical Therapy
Business Office
HIPAA Privacy Officer
415 W Wheatland Rd #102, Duncanville, TX 75116

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose your protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission and we are required to maintain in our records of the care that we provided to you.

CONTACT INFORMATION

When communicating with us regarding this Notice, our privacy practices, or your privacy rights, please contact us using the following contact information:

Advance Therapy PC
Business Office
HIPAA Privacy Officer
415 W Wheatland Rd #102, Duncanville, TX 75116

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have been given the Notice of Privacy Practices for Advance Therapy PC. 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.

Patient's or Authorized Representative's

_____ _____

Printed Name Signature

_____

Date

Office use only:

Witness: _____ Date: _____

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 reasonability 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 **$50.00** 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: _____