A Step Ahead Physical Therapy

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐Male ☐Female Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Email Address: _____

REMINDER METHOD

☐Text (cellular carrier _____) ☐Email ☐Phone Call

EMERGENCY CONTACT

Name: _____ Phone Number: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID # _____

Secondary Insurance: _____ ID # _____

CASE INFORMATION

Injury/Surgery Type: _____ Injury/Surgery Date: _____

Referring Physician: _____ Phone Number: _____

Date of Last Appointment: _____ Date of Next Appointment: _____

Primary Care Physician (if different): _____ Phone Number: _____

Was this a Motor Vehicle Accident? ☐ Yes ☐ No If yes, what state did the accident occur in? _____

Is this a Workers Compensation Case? ☐ Yes ☐ No

How did you hear about us? ☐ Doctor ☐ Family/Friend ☐ Internet Search ☐ Insurance Company ☐ Other

Whom may we thank for your referral? _____

Signature: _____ Date: _____

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A Step Ahead Physical Therapy

Patient Name: _____ **Today's Date:** _____

A Step Ahead Physical Therapy is dedicated to providing the best possible care for you in a warm, comfortable environment. All services are provided by a licensed Physical Therapist.

By signing below I acknowledge and consent to the following, where applicable:

1. **MEDICAL CONSENT:** I authorize A Step Ahead Physical Therapy to perform physical therapy assessment and treatment which will be discussed with my therapist.
2. **PAYMENT FOR SERVICES:** I understand that payment is expected at the time of service for all services and I am fully responsible for all fees that are not covered by my insurance except those prohibited by the insurance carrier. Insurance will be filed for services rendered as directed by me. Co-pays and co-insurance are expected at the time of service.
3. **MEDICAL INSURANCE BENEFITS:** A Step Ahead Physical Therapy will verify my insurance coverage prior to service and filing claims. Based on this information, A Step Ahead Physical Therapy will estimate the portion of charges for which I should be responsible, taking into consideration coordination of benefits should I have coverage under multiple insurance policies. There are no guarantees to the accuracy of the verification process or any payment amounts received from my insurance company. The final indicator of coverage is the Explanation of Benefits (EOB). I am responsible for any balances not covered by the policy.
4. **MEDICARE AUTHORIZATION:** I certify that the information given in applying for payment under TITLE XVII of the Social Security Act is correct and requests payment of authorized benefits to be made on my behalf. I authorize A Step Ahead Physical Therapy to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information needed for Medicare claims, including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished.
5. **SELF PAY DISCOUNT:** A discount is available to those who pay in full at the time of service and do not require A Step Ahead Physical Therapy to file claims with health insurance. If I choose for A Step Ahead Physical Therapy not to file claims or take any insurance information, I may file with my health insurance on my own. In this case A Step Ahead Physical Therapy will provide the proper receipts and documentation to be submitted.
6. **MEDICAL RECORDS RELEASE:** I authorize A Step Ahead Physical Therapy to release any medical records (including any information furnished to A Step Ahead Physical Therapy or obtained by A Step Ahead Physical Therapy in connection with my treatment) to any referring physician, insurance company, health care facility or government agency requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer.

I authorize the release of any medical information to the following person(s):

Name: _____ Relationship _____

Name: _____ Relationship _____

7. **SCHEDULING POLICY:** A Step Ahead Physical Therapy schedules a full hour of therapy for each patient. NO other patients are scheduled with that therapist at that time. This ensures I am receiving the best care and getting the most out of my rehabilitation.

8. **CANCELLATION POLICY:** A Step Ahead Physical Therapy asks that I give **24-hour prior notice for cancelling** or rescheduling appointments as a courtesy to the Therapists and to other patients trying to schedule appointments.
9. **SELF-REFERRED/DIRECT ACCESS:** I understand that a physical therapist diagnosis is not a medical diagnosis by a physician or based on radiological images and that such services might not be covered by my health plan or insurer. Self-Referred/Direct Access allows for treatment for 21 days or **8 visits** from the initiation of a physical therapy plan of intervention.
   I understand that if I am a self referred patient I am unable to receive dry needling without my Physical Therapist consulting with my Physician.
10. **STUDENT OBSERVATION:** A Step Ahead Physical Therapy has several observation internships with students within our clinic. Students are required to complete a certain number of observation hours before applying to a Physical Therapy Program. In regard to this A Step Ahead Physical Therapy has made me aware of my rights as a patient. I can request not to be observed by a student and different arrangements will be made, including a private room. My comfort is of utmost priority and every step will be taken to ensure that I feel comfortable with my treatment.

This is observation only; there is no 'hands on' treatment by any intern.

Yes, I allow students to observe my treatment. _____

No, I prefer no student observe my treatment. _____

11. **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE:** I acknowledge that I have been given a copy of the Notice of Privacy Practices and am providing consent for the use of my protect health information in the manner described in the Notice of Privacy Practices.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Today's Date:** _____

If Patient is a minor, to be signed by Parent or Guardian

Printed Name of Parent or Guardian: _____

FOR OFFICE USE ONLY

The following apply to the client: ☐ Self Referred/Direct Access

☐ Commercial Insurance ☐ Self Pay Discount ☐ Workers Compensation ☐ Auto Accident

A Step Ahead Physical Therapy will file with: ☐ Medicare ☐ In Network Insurance ☐ Out of Network Insurance

The above information was reviewed with the client by _____

A Step Ahead Physical Therapy Staff Signature: _____ Date: _____

A Step Ahead Physical Therapy

PHYSICAL THERAPY ASSESSMENT

Name: _____ Height: _____ Weight: _____ Age: _____ Date: _____

Highest Level of Education: _____ Employment: _____

Rate your health: ☐Excellent ☐Good ☐Fair ☐Poor Have you had any major life changes in the past year?☐Yes ☐No

Average Blood Pressure: _____ Are you: ☐ Right Handed ☐ Left Handed

Do you exercise regularly? ☐ Yes ☐ No If yes, how often and what types? _____

Tobacco use? ☐Never ☐Past ☐Current; If current type/how much?_____

Alcohol use? ☐Never ☐Past ☐Current; If current type/how much?_____

Do you have any customs/religious beliefs/wishes that might affect care? _____

Please list any relevant family history: _____

Medical/Surgical History: ☐Arthritis ☐Blood Disorders ☐Broken Bone/Fracture ☐Cancer _____
☐Circulation/Vascular ☐Depression ☐Developmental/Growth Problems ☐Diabetes ☐ Gynecological Problems
☐Head Injury ☐Hearing Problems ☐ Heart conditions or Heart Attack ☐High Blood Pressure ☐Infectious Disease
☐ Irregular Menstruation ☐Joint Replacement ☐Kidney Problem ☐Lung problems ☐Memory Problems_____
☐ Multiple Sclerosis ☐Osteoporosis ☐Parkinson's Disease ☐Prostate Disease ☐Seizures/Epilepsy ☐Stroke
☐Thyroid Problems ☐Ulcers/Stomach Problems ☐Other _____

Within the past year, have you had any of the following symptoms? ☐ Abdominal/Pelvic Pain
☐Bowel problems/ Constipation ☐Chest pain ☐Coordination Problems ☐Difficulty Sleeping ☐Difficulty Swallowing
☐Difficulty Walking ☐Dizziness/Blackouts ☐Falls; if yes #_____ ☐Headaches ☐Hearing Problems
☐Heart Palpitations ☐Joint Pain/Swelling ☐Loss of Appetite ☐Loss of Balance ☐Pain at Night
☐Shortness of Breath ☐Urinary Problems/Leakage ☐Vision Problems ☐Weakness in Arms/Legs ☐Weight Gain/Loss

Surgeries including approximate date: ☐ N/A

_____

_____

_____

Medications (prescription, nonprescription and supplements)
Include frequency and dosage; continue on back if necessary

☐ N/A _____

_____

_____

Who do you live with? ☐Alone ☐Spouse ☐Child
☐Other Relative ☐Other _____

Where do you live? ☐House ☐Apartment ☐Other_____

Does your home have: ☐ Stairs, no railing ☐Ramps
☐Stairs, w/railing ☐Uneven Terrain ☐Other _____

Do you use: ☐Cane ☐Walker ☐Manual Wheelchair
☐Motorized Wheelchair ☐Other _____

Allergies: Do you have a latex allergy? ☐Yes ☐No
List other allergies

_____

_____

For Women: Are you pregnant or think you might be pregnant? ☐Yes ☐No

Therapist Initials: _____

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PHYSICAL THERAPY ASSESSMENT

Name: _____ Date: _____

Current Condition:

When did this problem begin? _____

What happened? _____

Have you ever had this problem before? ☐Yes ☐No If yes, when? _____

If yes, what did you do for the problem? _____

How long did the problem last? _____ Did the problem get better? ☐Yes ☐No

How are you taking care of the problem now? _____

What makes the problem worse? _____

What activities are you not able to do now due to the problem? _____

What are your goals for physical therapy? _____

Are you seeing anyone else for the problem? _____

Clinical Tests Performed for this Condition:

☐Angiogram ☐Bone Scan ☐CT Scan

☐Electrocardiogram ☐Mammogram ☐MRI

☐NCV (Nerve Conduction Test) ☐Stress Test ☐X-Rays

Please rate the level of your pain:

At present: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Extreme

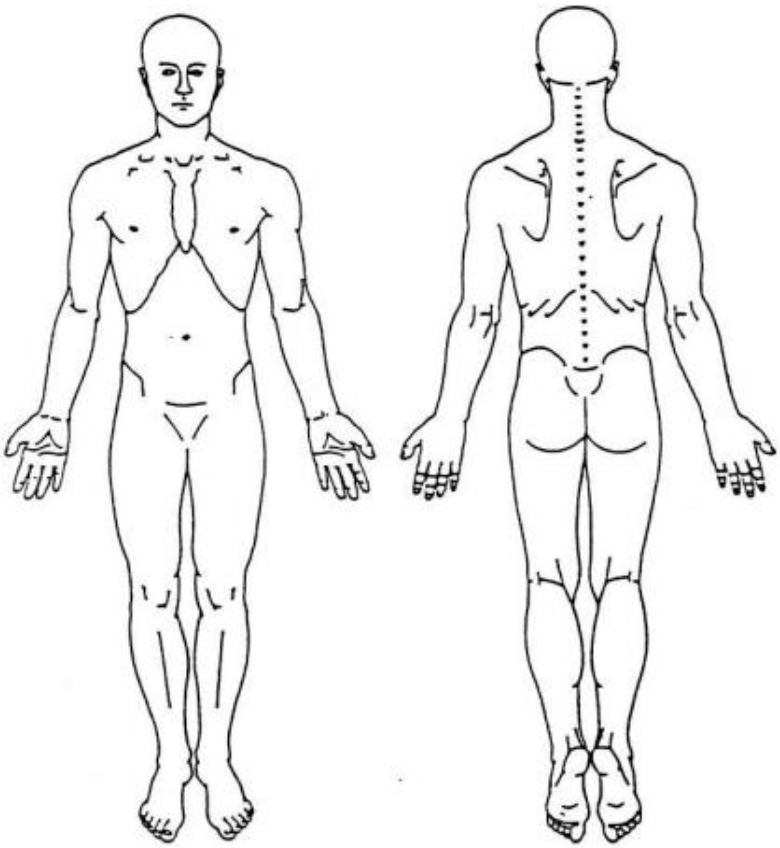
Which of these words describes your pain?

(circle all that apply)

Aching Burning Constant Cramping

Dull Numb Radiating Sharp Tingling

Please mark painful areas:



Therapist Initials: _____

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Name: _____ Date: _____

Here are some of the things which other patients have told us about their pain. For each statement please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect your pain.

	COMPLETELY DISAGREE			UNSURE			COMPLETELY AGREE
1. My pain was caused by physical activity	0	1	2	3	4	5	6
2. Physical activity makes my pain worse	0	1	2	3	4	5	6
3. Physical activity might harm my back	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
5. I cannot do physical activities which which (might) make my pain worse	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your pain.

	COMPLETELY DISAGREE			UNSURE			COMPLETELY AGREE
6. My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
7. My work aggravated my pain	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain	0	1	2	3	4	5	6
9. My work is too heavy for me	0	1	2	3	4	5	6
10. My work makes or would make my pain worse	0	1	2	3	4	5	6
11. My work might harm my back	0	1	2	3	4	5	6
12. I should not do my normal work with my present pain	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain	0	1	2	3	4	5	6
14. I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to that work	0	1	2	3	4	5	6

PA (2-5): _____ W (6,7,9-12,15): _____

FAB-Q Therapist Initials: _____

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NOTICE OF PRIVACY PRACTICES

Updated June 2016

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

USES AND DISCLOSURES: Your protected health information (PHI) will be used for the purposes of treatment and health care operations. Please see examples of each below.

Treatment: Sharing of medical information between healthcare providers that are involved in your care (i.e. your physician, other therapists, etc.).

Payment: Sending of billing information to your insurance company.

Health Care Operations: Periodic quality assurance monitoring.

Other Special Uses: Use of your PHI to contact you for an appointment reminder or to inform you of other health-related services.

In addition to the above uses, your PHI may be utilized or disclosed under the following circumstances:

- With a family member or friend involved in your care if you do not object
- In an emergency situation when you may not be able to express yourself
- When required by law, by court order or subpoena
- When necessary to comply with Worker's Compensation, U.S. Military, or similar programs that provide benefits for your work-related injury or illness
- When necessary to prevent or lessen a serious threat to the health or safety of another person or the public

For all other uses not mentioned above, you will be asked for your written authorization.

PATIENT PRIVACY RIGHTS

Restrictions: You have the right to request restrictions on how your PHI is used; however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential: You have the right to request communications in a confidential manner such as providing alternate address or phone number. We are an open clinic with patients receiving treatment in close proximity to each other. Private rooms are available upon request. Not all treatments are able to be performed in a private room.

Access to Medical information: You have the right to inspect or request a copy of your medical information. A reasonable fee for copying and postage may be charged.

Amendments: If you disagree with any of your PHI, you have the right to request in writing an amendment be made. If a mutual agreement cannot be made, then the request is not required to be granted. In this case, your written statement of disagreement will become a part of your record. Also, any part of your medical record that was created by other entities or providers may not be amended by this provider.

Accounting of Disclosures: You have the right to request an accounting of the disclosures made except for those that were made with your specific authorization or for treatment, payment or health care operations.

COMPLAINTS

At any time that you feel that your privacy rights have been violated, you may register a complaint in writing to Brad Freemyer, PT @ 930 Woodstock Rd, Suite 310, Roswell, Ga 30075. In no circumstance will you be penalized or receive retaliation for any complaint. If you are not satisfied with the response to your complaint, you may complain directly to the U.S. Secretary of Health and Human Services.

OUR DUTY TO PROTECT YOUR PRIVACY

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, Our Notice of Privacy Practices and to follow the terms listed. We reserve the right to update this notice. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.