Advanced PT, LLC
200 W Douglas Ave, Ste 1040
Wichita, KS 67202
(866) 412-5554

Welcome to Advanced PT, LLC. We are honored that you have chosen us as your therapy provider. Our goal is to provide the highest quality of care for all of our patients through excellent customer service and personalized therapy.

You can expect us to:

- Verify and manage as much of your health insurance requirements as permitted, for your convenience;
- Dedicate an exclusive appointment time to provide professional, one-on-one therapy care tailored specifically for you;
- Attentively listen to your rehabilitation concerns and provide realistic solutions;
- Stay focused on your needs throughout treatment to ensure the best possible outcome.

The following is our registration packet. While we understand the paperwork may seem lengthy, we ask that you complete all applicable fields. Accurate information will allow us to better serve you through your entire experience with us.

Should you have questions or concerns at any time, please feel free to contact your specific clinic. Their phone number is available on our website, if you have not been previously provided with it. You may also contact any of the following individuals located at our business office, (866) 412-5554, should you feel that be necessary:

Rachel Hamilton, Marketing and Customer Service Director, extension 1006
Janet Ewy, Billing Manager and Privacy & Compliance Officer, extension 1012
Angie Jozefowicz, Human Resources and Accounting Manager, extension 1011
Jesse Kersten, Practice Management and IT Manager, extension 1109
Jolene Peoples, Client Relations Manager, extension 1000

We sincerely look forward to helping you achieve your goals and meeting your expectations.

Advanced PT's Therapy Team

Advanced PT, LLC

Patient Information Form

Patient Information

Last Name: _____ **First Name:** _____ **MI:** ____

SSN: _____-_____-_____ **Date of Birth:** _____/_____/_____ **Gender:** _____

Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email (Required): _____ **Marital Status:** _____

Primary Care Physician: _____

How did you hear about us? Please circle all that apply.

Referring Doctor	Employee	Former Patient	Social Media	Returning Patient
Magazine/Newspaper	Mailer	Radio	Website	Other

If underlined option or "Other" is selected, please specify: _____

Employment Information

Employment Status: Full-Time Part-Time Self-Employed Not Employed
Retired Student Active Duty

Employer Name: _____

Employer Address: _____

Work Phone: _____ **Job Title:** _____

Emergency Contact Information

Emergency Contact First and Last Name: _____

Phone: _____ **Relationship:** _____

Insurance Information

Have you verified your therapy benefits with your insurance? If not, we strongly encourage you to do so.

Primary Insurance: _____ **Member ID #:** _____

Policy Holder: _____ **SSN:** _____ **Date of Birth:** _____

Relationship to Patient: _____ **Policy Holder's Employer:** _____

Secondary Insurance: _____ **Member ID #:** _____

Policy Holder: _____ **SSN:** _____ **Date of Birth:** _____

Relationship to Patient: _____ **Policy Holder's Employer:** _____

Responsible Party (Must be parent or legal guardian if patient is a minor.)

Last Name: _____ **First Name:** _____ **MI:** ____

SSN: _____-_____-_____ **Date of Birth:** _____/_____/_____ **Gender:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email:_____ **Relationship to Patient:** _____

Advanced PT, LLC Patient Name: _____

Patient Information Form (continued)

Additional Information

What is your primary language? _____

Do you need an interpreter? YES / NO

Auto Insurance

Is this as a result of an Auto Accident? YES / NO Date of Accident:_____

In what city and state did the accident occur? _____

Please provide YOUR auto insurance information. State law requires that we file with the patient's auto insurance - regardless of who was at fault in the motor vehicle accident.

Auto Insurance Company: _____

Policy #: _____ **Claim #:** _____

Adjustor's Name: _____ **Adjustor's Phone #:** _____

Claims Mailing Address: _____

PIP Limit: $_____ **PIP Used-to-Date: $**_____

Is this a Lawsuit? YES / NO

Law Firm Name: _____

Attorney Name: _____ **Attorney Phone:** _____

Worker's Compensation

Is this as a result of a work place injury? YES / NO Date of Injury: _____

In what city and state did the injury occur? _____

Employer's Name: _____

Employer's Phone #: _____ **HR Contact:** _____

Employer Headquarters - City/State: _____ **Job Title:** _____

Is this an approved Worker's Comp Injury? YES / NO

Law Firm Name: _____

Attorney Name: _____ **Attorney Phone:** _____

Advanced PT, LLC Patient Name: _____

Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my dedicated appointment time. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and that **cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $25**.

   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjustor and/or Rehabilitation Manager of all missed, canceled, or rescheduled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at time of service. I acknowledge that in consideration of the services provided to me by Advanced PT, LLC, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Advanced PT, LLC with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may decide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. A full Financial Policy is available upon request.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Advanced PT, LLC all my rights and claims for reimbursement under my insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that «Clinic Name» may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Advanced PT, LLC's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Advanced PT, LLC's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. **HIPAA CONSENTS:** In accordance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding scheduled appointments, the treatment I receive and the billing of my account:

_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship

I also authorize the release of appointment information left in a voice-mail, answering machine, text message or email and understand that there is some level of privacy risk associated with these forms of communication.

By signing my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____ _____

Signature of Patient or Legally Responsible Person **Date**

_____

Printed Name of Above

Advanced PT, LLC Patient Name: _____

Appointment Reminder Consent Form

Complete this form and sign below to give your permission for Advanced PT, LLC to provide automatic appointment reminder service by email or by cell phone text message. By authorizing us to do so, you acknowledge understanding that there is some level of privacy risk associated with these forms of communication.

Step One: Select <u>One</u> Option Below

☐ Advanced PT, LLC may send email messages to confirm my upcoming appointments to _____

☐ Advanced PT, LLC may send cell phone text messages to confirm my upcoming appointments to _____
I recognize that normal text messaging rates may apply.

☐ I prefer not to be contacted by email or text message for appointment reminders.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

Please understand that there may be times that these reminders are not functioning properly due to system or cell phone issues that we may not be aware of. While we are committed to resolving any issues that arise, these reminders cannot be guaranteed and you should not solely rely on these reminders for your appointments. We ask that you, as the patient or patient's responsible party, still ultimately be responsible for your schedule. We at Advanced PT, LLC are patient advocates and will do our best to work with you to provide great customer service.

_____
Signature of Patient or Guardian

_____
Date

Advanced PT, LLC Patient Name: _____

Medical History Form Please answer to the best of your ability.

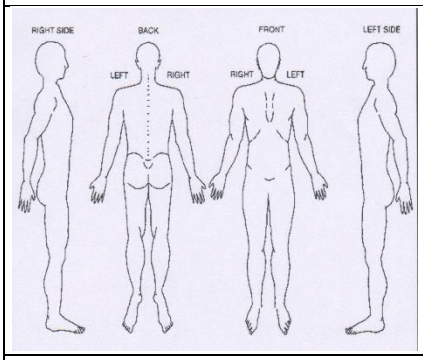
Date of Injury: _____ **Cause of Injury:** _____

Was this related to either of the following? (Circle one, if appropriate.) Work Related OR Motor Vehicle Accident

Have you ever had these symptoms before? YES / NO **Have you had a related surgery?** YES / NO

Are you receiving any Home Health Services? YES / NO

Indicate where you have pain/symptoms on the body charts with an X:



Rate your pain from 0-10 (0=no pain, 10=excruciating) for the following:

Worst it has been: _____ Best it has been: _____

At this moment: _____

Indicate the nature of your pain and symptoms (circle all that apply):

Sharp Aching Shooting Dull Tingling Burning Numb

Is the pain constant? _____ **Or does it come and go?** _____

Do you use tobacco products? YES / NO

Have you had any physical therapy or occupational therapy in the last 6 months? YES / NO

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Diabetes	Y	N	Allergies to Aspirin	Y	N	Are you pregnant?	Y	N
Chest Pain / Angina	Y	N	Poor tolerance to hot or cold	Y	N	Surgeries	Y	N
High Blood Pressure	Y	N	Asthma or breathing difficulties	Y	N	Headaches	Y	N
Heart Disease	Y	N	Other Allergies	Y	N	Heart Attack	Y	N
Heart Palpitations	Y	N	Seizures	Y	N	Hernia	Y	N
Pacemaker	Y	N	Metal Implants	Y	N	Cancer	Y	N
Dizziness / Fainting	Y	N	Recent Fractures	Y	N	Stroke / CVA	Y	N
Kidney Problems	Y	N	Skin Abnormalities	Y	N	Urine Leakage	Y	N
Liver Problems	Y	N	Sexual Dysfunction	Y	N	Hypoglycemia	Y	N
Gallbladder Problems	Y	N	Special Diet Guidelines	Y	N	Infectious Diseases	Y	N
Nausea / Vomiting	Y	N	Ringing in your ears	Y	N	Osteoporosis	Y	N
Rheumatoid Arthritis	Y	N	Bowel / Bladder Abnormalities	Y	N	Other / Specify Below		

If you answered Y to any of these, please specify.

_____

_____

_____

Please list all medications, including prescriptions, over the counter, vitamins, and dietary supplements. Include the dosage, frequency, and administration method for each medication. Attach additional page, if necessary.

Medication	Dosage	Frequency	Method of Administration

Please briefly describe any falls you have had in the past year. If necessary, continue the list on to the back of this page.

When? (Approximately)	What Happened?	What kind of injury?

If no falls, check here. _____

Completed By: _____ Date: _____

(Please print your name)

FOR OFFICE USE ONLY -- REQUIRED FOR MEDICARE		Patient's BMI Score:			
Patient's Height:	Patient's Weight:	BMI FINDINGS: (circle one)	Below Normal	Normal	Above Normal