ADVANCED PHYSICAL THERAPY CENTER
1065 Clayton St., Suite 9 Conway, AR 72032 (501) 328-5878
www.advancedptcenter.com

Patient Name _____ Age: _____ Sex: _____ Birthdate _____
Patient SSN _____ Phone # _____ 2nd # _____
Mailing Address _____ Email: _____
City _____ State _____ ZIP _____
Name of person responsible (if not patient) _____
In case of emergency, notify : _____ Phone _____

Employer of Patient or Responsible Party _____
Employer Address _____
City _____ State _____ ZIP _____

Is your current problem the result of an accident? ___ Yes ___ No
If yes, were you injured at _____ work _____ school _____ auto _____ home _____ other
Date of Injury _____ If not an accident, date when symptoms began _____

My primary insurance is: _____ Private Insurance _____ Worker's Comp _____ Medicare _____ Auto
Insurance Co. or Worker's Comp Carrier Name: _____
Name of insured as it appears on Insurance ID card _____
ID # _____ Group # _____
Insurance Co. Address _____ Phone #_____
City _____ State _____ ZIP _____

Secondary Insurance Company Name: _____
Name of insured as it appears on card: _____
Birthday of insured: _____
ID # _____ Group # _____
Insurance Co. Address _____ Phone #_____
City _____ State _____ ZIP _____

I hereby request and authorize my insurance companies and/or Medicare to pay directly to Advanced Physical Therapy Center any proceeds payable under the terms of my policy and/or policies. I understand and agree any unpaid balance not covered by this policy is my responsibility and will be paid in full by me. I also give my consent to Advanced Physical Therapy Center to release medical information to my insurance companies and/or Health Care Financing Administration.

_____

Signed (If minor, responsible party must sign) **Date**

ADVANCED PHYSICAL THERAPY CENTER
1065 Clayton St., Suite 9 Conway, AR 72032 (501) 328-5878
www.advancedptcenter.com

CONSENT, DISCLOSURE, AND PRIVACY

I hereby give consent to the licensed physical therapists and other trained professionals under their supervision employed by Advanced Physical therapy Center to evaluate my condition, provide and implement a plan of care, and supervise and monitor my progress.

If I am to have my account paid by health insurance, workman's compensation, or auto insurance, I hereby request and authorize my insurance company(s) or Medicare to pay directly to Advanced Physical Therapy Center any proceeds payable under the terms of my policy(s) for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospital and physical therapy pre-certifications, deductibles, co-insurance, and co-payment.

It is the policy of Advanced Physical Therapy Center to help the client in obtaining full benefits from his/her insurance company. However, the clinic is not obligated to withhold our statements or to wait until settlement has been made before receiving payment for our services.

I have been provided an opportunity to review and received a copy of Advanced Physical Therapy Center's privacy policies.
Our office is happy to file medical claims with your insurance carrier. Once we have received payment from your insurance company, any remaining balance on your account not already collected is due and payable **within thirty (30) days** of receiving the insurance payment. ***Co-pays and co-insurance payments are due at time of service.*** The benefits that we explain to you are only an ***estimate of benefits***. It is your responsibility to know your insurance policy and how they pay **(i.e. your deductible, your copay, and/or co-insurance).**

Advanced Physical Therapy Center also reserves the right to utilize the services of a collection agency in collecting delinquent accounts. If a collection service is utilized, I agree to pay all such costs incurred in collecting my account balance, including attorney's fees. If my check is returned for insufficient funds, I agree to pay a returned check fee of $25 for each occurrence.

_____

Signature of Client (Parent/Guardian if client is under 18 years of age) **Date**

_____

PRINTED NAME OF CLIENT

_____

Witness/APTC Representative **PRINTED NAME**

ADVANCED PHYSICAL THERAPY CENTER
1065 Clayton St., Suite 9 Conway, AR 72032 (501) 328-5878
www.advancedptcenter.com

INDIVIDUAL PATIENT'S AUTHORIZATION FOR PROTECTED HEALTH INFORMATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

Protected Health Information to Be Used and/or Disclosed
The only protected health information that Advanced Physical Therapy Center might disclose is physical therapy documentation. This would include daily notes, evaluations and progress reports, home exercise programs, self assessments, and referral information.

_____ **Initial here if you agree.**

Should you feel there is any other information you wish to be disclosed or not disclosed please explain:
_____

People or Organizations Permitted to Receive and Use
Name the people and/or organizations you are authorizing to receive and use your protected health information.

( ) Referring Physician
( ) Insurance
( ) Worker's Compensation
( ) Other: explain _____
( ) Coach/Athletic Trainer
( ) Attorney
( ) Immediate family (parents, children, siblings)

Purposes of the Requested Uses and/or Disclosures
The only reason Advanced Physical Therapy Center will disclose protected health information is to your medical care provider and for reimbursement reasons. APTC provides your physician with a copy of your evaluation and also progress notes. Upon request by your insurance company, we will provide them with copies of all physical therapy documentation.

_____ **Initial here if you agree.**

ENDING THE AUTHORIZATION
Select one of the following two choices:
( ) This authorization will end on the following date: _____/_____/_____.
( ) This authorization will end when the following event happens:
- ( ) 10 years after last visit, or
- ( ) Other - explain: _____
- ( ) No ending date specified

INDIVIDUAL PATIENT'S SIGNATURE
I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____
If this authorization form is signed by a personal representative for the individual patient, complete the following:
Personal Representative's Name: _____
Signature: _____ Date: _____
Relationship to Individual Patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT

Office Use Only	Ht._____ Wt._____	BP_____	Pulse_____

PRE-EXAM FORM: **In order to evaluate your condition fully, please be as accurate as possible. Thank you.**

PATIENT NAME:_____ AGE:_____ GENDER ID: ☐ Female ☐ Male

OCCUPATION:_____ ARE YOU WORKING NOW? ☐ Yes ☐ No

REFERRED BY: _____ ☐CASH ☐WORK COMP ☐MEDICARE ☐ OTHER:

1.	Where is your pain/problem? (If needed, use body map on reverse.)		
2.	What caused your pain/problem?		
3.	Approximately when did it start?	☐ chronic (>6 mos)	
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	☐ Yes (If yes, when and describe?) ☐ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at all.....Mildly optimistic.....Fairly.....Very optimistic.....Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
12.	List any medications you are taking:		
13.	List all past surgeries with dates:		
14.	List all medical conditions you have (or were told you have):		
			Total:

Please use reverse for any additional information and complete body chart to indicate symptoms.

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

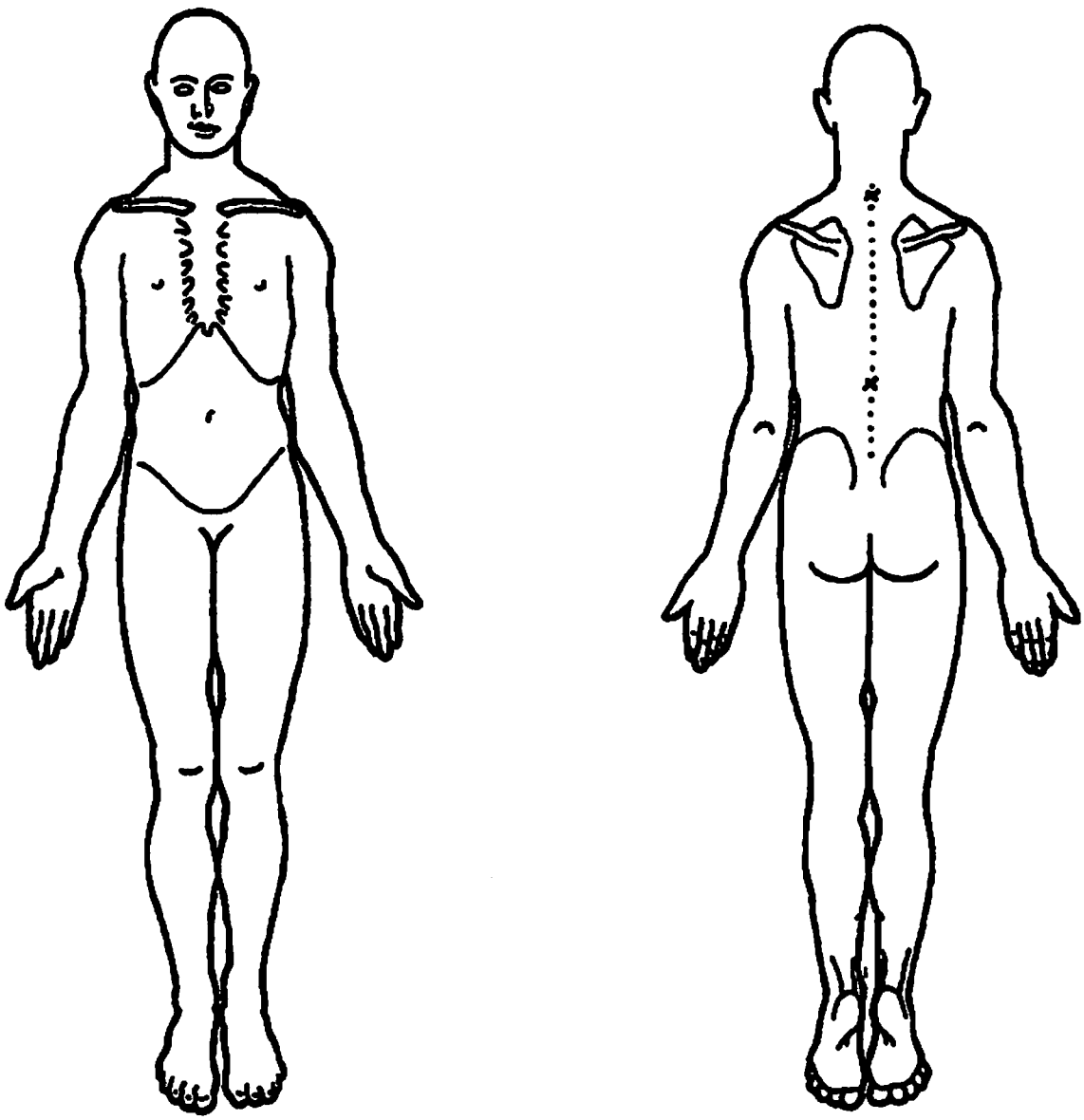
Patient Signature (or guardian):_____ Date: _____

Advanced Physical Therapy Center

Pain Neuroscience Education Program

Name: _____ **Date:** _____

Please use the diagram below to describe the symptoms you are concerned about.



Advanced Physical Therapy Center

Pain Neuroscience Education Program

Neurophysiology of Pain Questionnaire

(Revised)

Name: _____ **Date:** _____

Please circle T (true), F (false), U (unsure) for each of the following statements.

1. It is possible to have pain and not know about it.	**T**	**F**	**U**
2. When part of your body is injured, special pain receptors convey the pain message to your brain.	**T**	**F**	**U**
3. Pain only occurs when you are injured or at risk of being injured.	**T**	**F**	**U**
4. When you are injured, special receptors convey the danger message to your spinal cord.	**T**	**F**	**U**
5. Special nerves in your spinal cord convey 'danger' messages to your brain.	**T**	**F**	**U**
6. Nerves adapt by increasing their resting level of excitement.	**T**	**F**	**U**
7. Chronic pain means that an injury has not healed properly.	**T**	**F**	**U**
8. Worse injuries always result in worse pain.	**T**	**F**	**U**
9. Descending neurons are always inhibitory.	**T**	**F**	**U**
10. Pain occurs whenever you are injured.	**T**	**F**	**U**
11. When you injure yourself, the environment that you are in will not affect the amount of pain you experience, as long as the injury is exactly the same.	**T**	**F**	**U**
12. The brain decides when you will experience pain.	**T**	**F**	**U**