ADVANCED PHYSICAL THERAPY

Physical Therapy Intake Form

Patient Name: _____ DOB: _____

Who referred you? _____

History

Exercise Frequency: _____ Exercise Type(s): _____

Do you smoke? _____ Have you ever smoked? _____ How Often? _____

Are you pregnant? _____ Do you have a Pacemaker? Yes / No

Allergies: _____

What medication are you currently using? _____

Previous complaints/surgeries: _____

Previous diagnoses/mediation: _____

Complaint

What is your major complaint? _____

Start Date: _____ Possible cause: _____

Symptoms: _____

Previous doctors seen for complaint: _____

Previous treatment for complaint: _____

Symptoms Aggravating Factors: _____

Symptoms Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time They Are Worst: _____

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

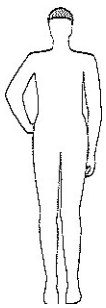
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

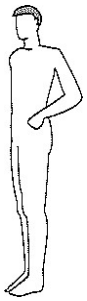
Is your pain getting better or worse? _____ Have you had this injury before? _____

Do You Have Any of the Following Today? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Area of Discomfort





Patient Signature: _____ Date: _____

ADVANCED PHYSICAL THERAPY

ASSIGNMENT OF BENEFITS (AOB), RELEASE OF INFORMATION (ROI) AND FINANCIAL AGREEMENT

Patient's Name: _____ Date of Birth: _____

Thank you for choosing **Advanced Pain Care and its sub-specialties, affiliated and related entities** your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

A patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the Billing Department.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee coverage or payment.
2. All charges are your responsibility whether your insurance company pays or not.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. Returned checks will be subject to a $25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.
6. Office visit no shows without 24-hour notice, are subject to a $25.00 charge.
7. Paperwork requiring completion by a provider will incur a $75.00 charge. Including but limited to disability, FMLA, etc.
8. Unpaid balances over 90 days may be subject to collection via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate about any such problems so that we can assist you in the management of your account.

Procedure No Show, Cancellations & Reschedules within 72 hours:
At the time of scheduling, a credit card will be obtained and securely placed on file. Failure to show on the scheduled day, or cancellation or rescheduling made within 72 hours of the procedure, will incur a $75 fee.

Authorization to Release Billing Information and Assignment of Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Advanced Pain Care and its sub-specialties, affiliated and related entities** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

Patient Signature_____ Date: _____

Relationship to patient if not patient _____

Mark Malone MD PA includes Advanced Pain Care and sub-specialties, affiliated and related entities.

ADVANCED PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: _____ DOB: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain PATIENT RIGHTS regarding my protected health information.

I understand that Advanced Pain Care, its subspecialty, Advanced Surgical Center may use or disclose my protected health information for treatment, payment, or health care operations- which means for: providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses or disclosures of this information without my authorization.

I authorize Advanced Pain Care, its subspecialty, Advanced Surgical Center to communicate with my **PCP** *(Primary Care Physician)***: Dr.**_____ Phone #: (____) _____

Advanced Pain Care, its subspecialties, affiliated and related entities has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the ***'Notice of Privacy Practices'*** before signing this agreement. If I ask, Advanced Pain Care, its subspecialty, Advanced Surgical Center Surgical Center will provide me with most current ***'Notice of Privacy Practices'.***

My signature below indicates that I have been given the chance to review such copy of the ***'Notice of Privacy Practices'.*** My signature means that I agree to allow Advanced Pain Care, its subspecialty, Advanced Surgical Center to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke the consent in writing at any time, except to the extent that Advanced Pain Care, its subspecialty, Advanced Surgical Center has taken action relying on this consent.

_____ _____

Patient Signature ***Date***

_____ _____

Relationship to Patient if signed by another party ***Date***

You may obtain a copy of our ***'Notice of Privacy Practices'*** including any revisions to our ***'Notice of Privacy Practices'*** at any time by contacting: Advanced Pain Care, its subspecialty, Advanced Surgical Center at 2000 S. Mays St, Round Rock Texas 78664 or (512) 244-4272.

****** OFFICE USE ONLY ******

Staff initial below when completed

Consent dates have been updated in Athena _____

ADVANCED PHYSICAL THERAPY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

- I authorize Advanced Pain Care and it's sub-specialties to release information from my Medical Record as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Check all that apply to the above names:

Failure to designate any limitations on the release of PHI below shall result in authorization to release all medical records.

- ☐ Regarding appointment, time & date
- ☐ Discuss medical care, an issue or concern
- ☐ Discuss Billing Information
- ☐ Discuss Lab Results
- ☐ Pick up Prescriptions
- ☐ Discuss Imaging Results
- ☐ Pick up Forms

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to **Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664**. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected. I understand that Advanced Pain Care will not condition treatment on whether I sign this authorization.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

This authorization will expire in 1 year from the date of signature unless another date is specified: _____

Patient Signature	Date
Legally Authorized Representative	Relationship to Patient

ADVANCED PHYSICAL THERAPY

Physical Therapy Informed Consent

Patient Name: _____ **DOB:** _____

Physical therapy involves the use of many different types of physical evaluation and treatment. At Advanced Pain Care Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

At Advanced Pain Care Physical Therapy we treat multiple patients during set times. Due to patient privacy family members or care takers will not be allowed in the Physical Therapy room. There is a waiting area located outside the room.

ARTIFICIAL INTELLIGENCE (AI) DOCUMENTATION NOTICE: Our practice uses artificial intelligence (AI) technology within our electronic health record (EHR) system to assist with administrative and clinical documentation, including the dictation and transcription of office visits.

_____ _____

Patient Signature Date

ADVANCED PHYSICAL THERAPY

Patient Name: _____ **DOB:** _____

Quality: Demographics

Language

☐English ☐Spanish ☐Other: _____

Race

☐ American Indian or Alaskan Native

☐ Asian

☐ Chinese

☐ Filipino

☐ Japanese

☐ Black or African American

☐ White or Caucasian

☐ Native Hawaiian

☐ Multi-Racial

☐ Other: _____

Ethnicity

☐Hispanic or Latino ☐Non-Hispanic or Latino

Marital Status

☐Married ☐Single ☐Widowed ☐Partner

Portal Email

Please provide email for patient portal access: _____

Consent to Text, Call and leave detailed voice messages

Do you give Advanced Pain Care permission to text you? ☐Yes ☐ No

Do you give Advanced Pain Care permission to call you? ☐ Yes ☐No

Consent for communication of medical information via voice message

Do you give Advanced Pain Care permission to leave a detailed voice message on your phone regarding your healthcare? This may include but is not limited to information about upcoming surgical procedures, appointment information, payment information, lab results, and other health-related information. ☐ Yes ☐ No

_____ _____

Patient Signature ***Date***

****** OFFICE USE ONLY ******

Staff initial below when completed

Race / Ethnicity / Language updated in Athena _____

Portal Registration: Y or N If no, did they decline and you printed portal URL? Y or N _____

ADVANCED PHYSICAL THERAPY

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

Notice Informing Individuals About Nondiscrimination and Accessibility

Discrimination is Against the Law

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) [optional: (or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Michael Jensen, Compliance Officer and Civil Rights Coordinator.

If you believe that Advanced Pain Care/Advanced Surgical/Advanced Pharmacies has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Michael Jensen, Compliance Officer and Civil Rights Coordinator, 101 Louis Henna Blvd., Ste 300, Austin, TX 78278, Tel: 512-244-4272, Fax: 512-244-2895, or at compliance@advancedpaincare.us.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Michael Jensen, Compliance Officer and Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Advanced Pain Care's website: https://austinpaindoctor.com

By signing below, I acknowledge that I have been given this notice.

Patient Signature: _____ **Date:** _____