Advanced Physical Therapy and Rehabilitation Center, LLC

Patient Information			Primary Care Physician Referring Physician
Last Name First Name M		Nickname	
Address	City	State	Zip Code
Phone (Home)	(Cell)	Birthdate(MM/DD/YYYY) Male ❑ Female ❑	
Marital Status Single ❑ Married ❑ Divorced ❑ Widowed ❑		Social Security Number	

Guarantor Information

Last Name First Name M		Relationship to Patient	
Address	City	State	Zip Code
Phone (Home)	(Cell)	Birthdate(MM/DD/YYYY)	
Social Security Number		Employer	

Employer Information

Occupation		Employer	
Employer Address	City	State	Zip Code
Work Phone		Extension	

Insurance Information on Primary

Insurance Company Name	Effective Date of Coverage	Co-Payment Amount

Address	City	State	Zip Code
ID/Policy Number		Group Number/Name	
Subscriber/Insured Name		Relationship to Patient	
Social Security Number		Birth Date (MM/DD/YYY)	

Continued next page:

Advanced Physical Therapy and Rehabilitation Center, LLC

Insurance Information on Secondary

Insurance Company Name		Effective Date of Coverage	Co-Payment Amount
Address	**City**	**State**	**Zip Code**

ID/Policy Number	Group Number/Name
Subscriber/Insured Name	**Relationship to Patient**
Social Security Number	**Birth Date (MM/DD/YYY)**

Insurance Information on Secondary

Emergency Contact

Name #1	Relationship to Patient

Home Phone	Cell Phone	Work Phone

Name #2	Relationship to Patient

Home Phone	Cell Phone	Work Phone

Assignment and Release

Authorization to treatment and release information to insurance carrier for direct payment to the provider.
I authorize treatment and the release of any medical information (acquired in my treatment) to process claims to my insurance company.
I authorize direct payment from my insurance company to my provider. At any time I decide that I want to file my own claims, understand that payment in full will be required at the time of service.
I also understand that I will be financially responsible for all charges incurred.

Signature____ Date_________________________

Advanced Physical Therapy and Rehabilitation Center, LLC

REVIEW OF SYSTEMS

Do you now have any problems related to the following systems?
Circle Yes or No

Please explain any yes answers in the space to the right

Gastrointestinal

Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Heartburn	Y	N
Burping	Y	N
Blood in stool	Y	N

Other ______________________________

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Sweating	Y	N
Weight loss	Y	N
Weakness	Y	N

Other ______________________________

Eyes

Blurred Vision	Y	N
Double Vision	Y	N

Other ______________________________

Ear / Nose / Throat

Ear pain	Y	N
Hard of hearing	Y	N
Sore throat	Y	N
Runny nose	Y	N

Other ______________________________

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Memory problems	Y	N
Frequent headaches	Y	N

Other ______________________________

Endocrine

Excessive Thirst	Y	N
Fatigue	Y	N

Other ______________________________

Female Genitourinary

Frequent urination	Y	N
Urgent urination	Y	N
Pain on urination	Y	N
Vaginal discharge	Y	N
Urine leakage	Y	N
Lower abdominal pain	Y	N
Blood in urine	Y	N
Painful menstruation	Y	N

Cardiovascular

Chest Pain	Y	N
Shortness of Breath	Y	N
Varicose veins	Y	N
Palpitations	Y	N
Swelling of extremities	Y	N

Other ______________________________

Skin

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Change in fingernails	Y	N
Hair loss	Y	N

Other ______________________________

Musculoskeletal

Joint pain	Y	N
Back pain	Y	N
Neck pain	Y	N

Other ______________________________

Hematologic / Lymphatic

Swollen glands	Y	N
Easy bruising	Y	N

Other ______________________________

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Sputum	Y	N

Other ______________________________

Allergic / Immunologic

Seasonal allergies	Y	N
Sneezing	Y	N
Watery/Itchy	Y	N

Other ______________________________

Male Genitourinary

Pain in the testicles	Y	N
Penile discharge Y	N	
Blood in urine	Y	N
Night time urination	Y	N
Frequent urination	Y	N
Dribbling of urine Y	N	
Difficulty starting urine	Y	N

Other ______________________________

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PATIENT HISTORY FORM

Today's Date: ______________________________

Last Name: ________________________________ First Name: ____________________ Middle: ____________

Chief Complaint:
What is the main reason for your visit today? *(Describe your problem in detail)* _______________________

____

HISTORY OF PRESENT ILLNESS

Location of the problem:

____

How long does the problem last?

____

On a scale of 0-10, with 10 being the most painful, circle the number that best describes the problem.

0 1 2 3 4 5 6 7 8 9 10

Is anything else occurring at the same time?
Yes No If yes, please explain.

____
____

When did you first notice the problem?

____

Is the problem constant or variable?
Dull then sharp Very sharp then stops

Other ____

MEDICAL HISTORY

Medical History:

- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Seizure Disorder
- ❑ Cancer
  Organ____________
- ❑ Diabetes
- ❑ Gall Bladder Disease
- ❑ Heart Disease/Heart Attack
- ❑ Stroke/Mini-stroke
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Thyroid Disease
- ❑ Lung Problems
- ❑ Migraines
- ❑ Neck/Back Problems
- ❑ Reflux/Heart Burn
- ❑ Tuberculosis
- ❑ Other____

Procedure History:

Surgery	Date (year)
❑ Heart Bypass/Valve Replacement	____________
❑ Hernia Repair	____________
❑ Gallbladder Removed	____________
❑ Joint Replacement	____________
❑ Bladder/Kidney Surgery	____________
❑ Organ Transplant	____________
❑ Stomach Surgery	____________
❑ Appendix Removed	____________
❑ Back/Neck Surgery	____________
❑ Prostate Surgery	____________
❑ Tonsils Removed	____________

❑ Other____

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Are you taking any medications? Yes ______ No ______
(If yes, list all)

Name/Dosage	How often do you take this medicine?
1. ______	______
2. ______	______
3. ______	______
4. ______	______
5. ______	______
6. ______	______
7. ______	______
8. ______	______
9. ______	______
10. ______	______
11. ______	______
12. ______	______
13. ______	______
14. ______	______
15. ______	______

Family History:

List all serious illnesses in your **immediate family**. *Examples include Seizures, Headaches, Tremors, Dementia, etc.*

Illness	**Relationship**
___________________________________	______________________________
___________________________________	______________________________
___________________________________	______________________________

Social History:

Tobacco Use: ❑ Every Day ❑ Some Days ❑ Former Smoker ❑ Never Smoked

Type: ❑ Cigarettes ❑ Cigars ❑ Smokeless ❑ Pipe ❑ Other

Use Per Day ____________________ Number of Years Used _________________

If past use, age started ________________ Stopped at What Age _________________

Alcohol Use: ❑ Current Use ❑ Past Use ❑Never Used

Type: ❑ Beer ❑ Wine ❑ Liquor ❑ Other

Frequency:

❑ Daily ❑ 3-5 times/week ❑ 1-2 times/week ❑ 1-2 times/month ❑ 1-2 times/year

If past use, how long ago quit ___________

Illicit Drug Use: ❑ Current Use ❑ Past Use ❑ Never Used

Type: ❑ Amphetamines ❑ Cocaine ❑ Ecstasy ❑ Hallucinogens/LSD

❑ Heroin ❑ Inhalants/Glue ❑ Marijuana ❑ Methamphetamines

❑ Other ________________

Frequency:

❑ Daily ❑ 3-5 times/week ❑ 1-2 times/week ❑ 1-2 times/month ❑ 1-2 times/year

If past use, how long ago quit ___________

Allergies: Name	What kind of reaction do you have?
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

HIPAA Notice of Privacy Practices

Advanced Physical Therapy and Rehabitlitation Center, LLC
8230 Old Courthouse Road Suite 350
Vienna, VA 22182

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data, which can be used to identify you. This is health information that is created or received by your health care provider, and relates to your past, present, or future physical or mental health or condition. This information may be stored in either a paper or electronic format, or both.

Uses and Disclosures of Protected Health Information (PHI)

Your PHI may be used or disclosed by your physician or other primary care provider (collectively referred to as "provider"), our office staff and others outside of office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operation: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you may be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: As required by law; Public health issues required by law, including communicable diseases; Health Oversight; Abuse or neglect; Food or Drug Administration requirements; Legal proceedings; To law enforcement; To Coroners, Funeral Directors and Organ Donation Programs; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; For inmates.

Other permitted and required uses and disclosures will be made upon receipt of your consent or authorization. You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken action in reliance on the user or disclosure indicated in the authorization. Under the law, we must make disclosures to you upon request and when requested by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR § 164.500.

Your Rights

Following is a statement of you rights with respect to your protected health information (PHI).

You have the right to inspect and request copies of your PHI. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to such PHI. To receive a copy of your records, a written authorization must be completed. You may request to receive in an electronic format any of your records that are stored and readily producible in an electronic format.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may restrict the disclosure of your PHI to your health plan if services are paid for in full. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction applied. With exception of the aforementioned restriction to your health plan, your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to choose another health care provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to request to have your provider amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your PHI.

You will receive notification in the event of a breach that affects your unsecured PHI.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Privacy Officer in person or by phone at our main phone number.

This notice was published and becomes effective on June 4, 2013.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Patient/Guardian Signature:____

Print Patient Name:______________________________________ DOB:__________________

Today's Date:__________________________

ALL PATIENTS PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATON

I hereby authorize Advanced Physical Therapy to release such information as required by my insurance company/attorney in order to secure my insurance benefit. I also authorize my insurance company to pay Advanced Physical Therapy directly for services that they agree to bill for me. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.
Advanced Physical Therapy's policy is that payment is due when services are rendered. A $25 fee will be assessed for all returned checks. I also understand that if this account is not paid in a timely fashion, that I will be responsible for any collection/and or reasonable attorney fees incurred in the attempt to collect this debt.
I am aware that I am ultimately responsible for all services charged to me and I understand that these services are to be paid in a timely fashion regardless of any insurance companies with which I may participate with.

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature:____Date:___________

Parent or Guardian Signature:___________________________________Date:______________
(if under age 21, and adult must sign.)

Photo Release Form

Advanced Physical Therapy and Rehabilitation Center, LLC
8230 Old Courthouse Road, Suite 350 Vienna VA 22182

I hereby grant Advanced Physical Therapy and Rehabilitation Center the irrevocable right and permission to use photographs and or/video recordings of me on its websites and in publications, promotional flyers, educational materials, derivative works, or for any other similar purpose without compensation to me.

I understand and I agree that such photographs and/or video recordings of me might be placed on the Internet. I also understand and agree that I might be identified by name and/or title in printed, Internet or broadcast information that might accompany the photographs and/or video recordings of me. I waive the right to approve any final product relating to the photographs, video recordings, or information. I agree that all such portraits, pictures, photographs, video and audio recordings and any reproductions thereof, and all plates, negatives, recording tapes and digital files are and shall remain in the property of Advanced Physical Therapy and Rehabilitation Center.

I hereby release, acquit and forever discharge Advanced Physical Therapy and Rehabilitation Center, its current and former trustees, agents, officers and employees of the above-named entities from any and all claims demands, rights, promises, damages and liabilities, arising out of or in connection with the use or distribution of said photographs and/or video recordings, including but not limited to any claims for invasion of privacy, appropriation of likeness or defamation.

I hereby warrant that I am eighteen (18) years old or more and competent to contract in my own name or, if I am less than eighteen years old, that my parent or guardian signed this release form below. This release is binding on me and my heirs, assigns and personal representatives.

Signature of Individual Photographed/Recorded: ____

Printed Name of Individual Photographed/Recorded: ____

Date:________________

If the individual photographed/recorded is under eighteen (18) years old, the following section must be completed:

I have read and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am eighteen (18) years old or more and I am the parent or guardian of the child named above.

Signature of Parent/Guardian of Individual Photographed/Recorded: _____________________________

Printed Name of Parent/Guardian: ____

Date: ______________

Phone: 703-749-0223 fax: 703-749-0225