



**ADVANCED CARE
PHYSICAL THERAPY**

THANK YOU FOR CHOOSING ADVANCED CARE PHYSICAL THERAPY



You have an appointment for an evaluation with our office on _____ at _____. To assist us in treating you properly, please fill out this packet of information. Please bring this paperwork, along with the prescription from your doctor to our office. Please arrive 10 minutes prior to your appointment time. Please come in 20 minutes prior only if you have not completed this paperwork and/or need assistance. Please allow yourself at least an hour for the initial evaluation. Wear comfortable clothing. If you are being treated for your back or legs please bring a pair of shorts.

Please call the office if for any reason your appointment for your initial evaluation needs to be cancelled. Unless the initial evaluation is re-scheduled, all of your other scheduled appointments will be cancelled.



MEDICARE PATIENTS:

You will need to obtain another prescription from your physician if you are treated greater than 30 days.

MAMSI/OPTIMUM CHOICE/BLUE CHOICE PATIENTS:

Please make certain that you bring in a PCP referral if necessary.

PLEASE GIVE A 24-HOUR NOTICE FOR ANY CANCELLATIONS!

DRIECTIONS TO OFFICE:

FROM BELTWAY: 695 to exit 31 south. Go down to the third light, which is Linwood Ave. Make, a left on to Linwood Ave. And then an immediate left into our back parking lot. Make sure you enter though the back for our free parking.

FROM BALTO/CITY (SOUTH OF OFFICE): We are located a block north from Taylor Ave. The first light after Taylor Ave is Linwood Ave. Make a right on Linwood Ave. and then an immediate left into our back parking lot.

ADVANCED CARE PHYSICAL THERAPY

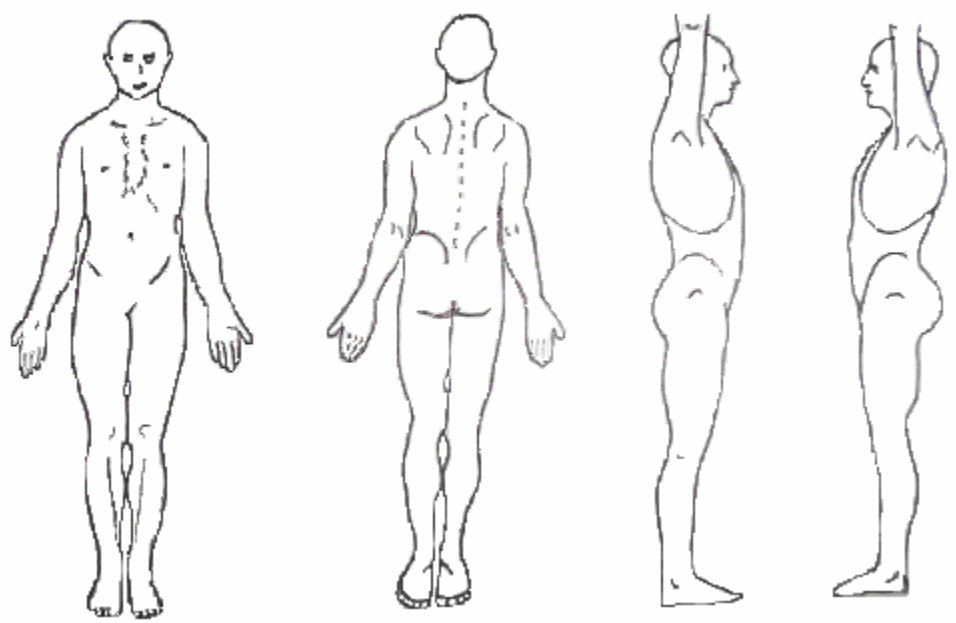
Name _____ Date _____

Referring Physician _____ Age _____ Sex _____

PLEASE COMPLETE QUESTIONS 1-5:

1. What is your major complaint? _____

2. Please place an (X) on the diagram below where your problem or problem exist:



3. Date of injury _____

4. How did the injury occur?

5. Was any surgery performed? _____ If yes, please answer below:
Date of surgery _____
What type of surgery was performed? _____



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DIRECTIONS: There are many words to describe pain. Some of these words are grouped below.
IF YOU ARE EXPERIENCING ANY PAIN, check any of the words that describe your pain.

1.Flickering Quivering____ Pulsing____ Throbbing____ Beating____ Pounding____	10.Tender____ Taut____ Rasping____ Splitting____		ACCOMPANYING SYMPTOMS: Nausea____ Headache____ Dizziness____ Drowsiness____ Constipation____ Diarrhea____	SLEEP: Good____ Fitful____ Can't Sleep____			
2.Jumping____ Flashing____ Shooting____	11.Tiring____ Exhausting____				FOOD INTAKE: Good____ Little____ None____		
3.Pricking____ Boring____ Drilling____ Stabbing____ lancinating____	12.Sickening____ Frightful____ Terrifying____					COMMENTS: 	
4.Sharp____ Cutting____ Lacerating____	14.Punishing____ Grueling____ Cruel____ Vicious____ Killing____						
5.Pinching____ Pressing____ Gnawing____ Cramping____ Crushing____	15.Wretched____ Blinding____ 16.Annoying____ Troublesome____ Miserable____ Intense____ Unbearable____						
6.Tugging____ Pulling____ Wrenching____	17.Spreading____ Radiating____ Penetrating____ Piercing____						
7.Hot____ Burning____ Scalding____ Searing____	18.Tight____ Numb____ Drawing____ Squeezing____ Tearing____						
8.Tingling____ Itchy____ Smarting____ Stinging____	19.Cool____ Cold____ Freezing____						
9.Dull____ Sore____ Hurting____ Aching____ Heavy____	20.Nagging____ Nauseating____ Agonizing____ Dreadful____ Torturing____						ACTIVITY: Good____ Some____ Little____ None____

Practice Name Advanced Care Physical Therapy
Address 8005 Harford RD. STE 102
City, State, Zip Parkville, MD 21234

Date _____

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

ADVANCED CARE PHYSICAL THERAPY
8005 HARFORD RD. SUITE 102
BALTIMORE, MD 21234

Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

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 also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20_____

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder

Advanced Care Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

Advanced Care Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are describe herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Advanced Care Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. We also provide information when required by law.

In any other situation, Advanced Care Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reason other than treatment, payment or other related administrative purposes.

For further information on Advanced Care Physical Therapy's health information practices, please contact the following person:

Advanced Care Physical Therapy
Candice Bonner, Office Manager
8005 Harford Rd. Suite 102
Baltimore, MD 21234
Telephone: 410-663-3133 Fax: 410-663-3089

ADVANCED CARE PHYSICAL THERAPY
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Advanced Care Physical Therapy's Notice of Information Practices. I understand that Advanced Care Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Patient Name

Signature

Date

ADVANCED CARE PHYSICAL THERAPY'S NON-SOCIALIZATION POLICY:
Employees and personnel of Advanced Care Physical Therapy, Inc., are professionals and are not permitted to socialize with or accept social invitations and/or request from patients.

1. As a patient of Advanced Care Physical Therapy, inc., I have been made aware of and agree to abide by Advanced Care Physical Therapy, Inc.'s above-stated Non-Socialization Policy.
2. I understand and agree that, as a Patient of Advanced Care Physical Therapy, Inc., I am not permitted to extend social invitations and/or request to Employees and/or Personnel of Advanced Care Physical Therapy, Inc.
3. I understand and agree that if, in Advanced Care Physical therapy's sole discretion, I violate the aforesaid Non-Socialization Policy, Advanced Care Physical Therapy, Inc. shall be entitled to discontinue treating me as a patient; and I hereby agree to accept such termination.

I have read, and understood, and signed this Policy acknowledgment on the date below.

Date

Patient Signature

Name: _____

Date _____

Referring Physician _____

Patient Screening Questionnaire

Medical History

Have you ever been told you have:

If yes, please explain in detail:

Circle One:

Cancer	yes	no
Diabetes	yes	no
Thyroid Condition	yes	no
Hypoglycemia	yes	no
Hypertension or high blood pressure	yes	no
Heart disease	yes	no
Angina or chest pain	yes	no
Shortness of breath	yes	no
Stroke	yes	no
Kidney disease or stones	yes	no
Urinary tract infection	yes	no
Allergies	yes	no
Asthma, hay fever	yes	no
Rheumatic / scarlet fever	yes	no
Hepatitis / jaundice	yes	no
Cirrhosis / liver disease	yes	no
Polio	yes	no
Chronic bronchitis	yes	no

Pneumonia	yes	no
Emphysema	yes	no
Migraine headaches	yes	no
Anemia	yes	no
Ulcers / stomach problems	yes	no
Arthritis / gout	yes	no
Vestibular / balance disorders	yes	no
HIV / AIDS	yes	no
Other	yes	no

Medical Testing

1. Have you had any x-rays, sonograms, computed tomography (CT) Scans or magnetic resonance imaging (MRI) performed in the last 6 months? yes no
- If yes, When? _____ Where? _____ Results? _____
2. Have you had any laboratory work performed in the last 6 months (Urinalysis or blood test)? yes no
- If yes, When? _____ Where? _____
- Results? _____

Medical Treatment

1. Are you receiving medical treatment for your condition that brings you to Physical therapy? Yes No
- If yes, please explain
- _____
- _____
- _____
- _____
2. Have you received previous medical care for your current condition? Yes no

If yes, please explain: (Examples: Acupuncture, Chiropractic, Cortisone injections etc.)

3. Please list any operations that you ever had and the date(s):

Type of Surgery:

Date of Surgery:

Medication

1. Are you taking any prescription, over the counter medications or supplements? Yes No

If yes, please list or provide or attach additional documentation:

General Health

1. Have you had any recent illness within the last 3 weeks? Yes No

2. Have you noticed any lumps or thickening of skin or muscle anywhere on your body? yes no

3. Do you have any sores that have not healed? Yes no

4. Do you have any changes in size, shape or color of a wart or mole? Yes no

5. Have you had any unexplained weight loss in the last month? Yes no

6. Have you experienced any unexplained nausea, vomiting or dizziness? Yes no

6. Do you smoke or chew tobacco? Yes no

If yes, how many packs / day? _____

For how many months or years? _____

7. Do you drink any alcohol? Yes no

- If yes, how much do you consume within a week? _____
8. How much caffeine do you consume during a week? _____
9. Are you on any special diet prescribed by your physician? Yes no
-

Special Questions for Men

1. Do you have difficulty with urination? Yes no
2. Do you have any blood in your urine? Yes no
3. Do you ever have pain during urination? Yes no
-

Special Questions for Women

1. Last Pap smear? _____
2. Last breast examination? _____
3. Do you perform a monthly breast examination? Yes no
4. Do you take birth control pills or are you using an intrauterine device? Yes no
5. Are you currently pregnant? Yes no
-

Work Environment

1. Occupation _____
2. Does your jobs involve:
- sitting greater than ½ hour (e.g., desk, computer, driving) yes no
- Standing greater than ½ hour (e.g., equipment operator, sale clerk) yes no
- Walking greater than ½ hour (e.g., mill work, delivery service) yes no
- Use of large or small equipment (e.g., telephone, fork lift, typewriter) yes no
- Lifting, bending, twisting, climbing, turning yes no
- Exposure to chemicals or gases yes no
- Other please describe: _____

3. Do you use any special supports?

Back cushion, neck cushion	yes	no
Back brace or corset	yes	no
Other kind of brace or support for any body part	yes	no

Leisure Activities:

1. Does your current condition limit you in any leisure activities or hobbies? Yes no

If yes, please specify in more detail: _____
