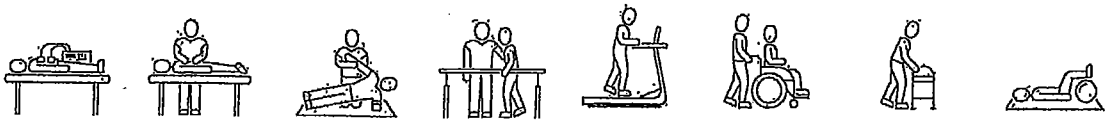
ADVANCED CARE
PHYSICAL THERAPY
Feel the Difference!

Thank you for choosing Advanced Care Physical Therapy



You have an appointment for an evaluation in our office on _____ at _____am/pm. To assist us in treating you properly, please fill out this packet of information. Be sure to bring this paperwork **completed**, along with the prescription from your doctor to our office, photo ID, and insurance cards. ***Please arrive 20 minutes prior to your appointment time.*** Allow yourself at least an hour for the initial evaluation.

Come prepared with comfortable clothing and appropriate shoe wear for the gym. Be sure to bring adequate swimming attire and a towel if your therapy involves the pool. If you are being treated for your legs or any lower extremity, please bring a pair of shorts.

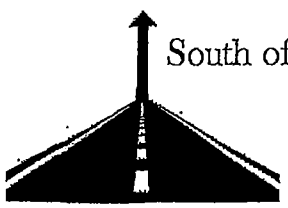
Please call the office if for any reason your initial evaluation appointment needs to be rescheduled. Unless the initial evaluation is re-scheduled, all of your following scheduled appointments will be cancelled.

Please give 24-hour notice for any cancellations

Patients should obtain a prescription from a physician for a specific area of injury and use it within 30 days.

Directions to Office

North of office: Beltway 695 exit 31 south. Go down to the 3rd light and make a left on Linwood Ave. **Make an immediate left into our back parking lot.**



South of office: We are located one block north of Taylor Ave. Make a right on to Linwood Ave. **Make an immediate left into our back parking lot.**

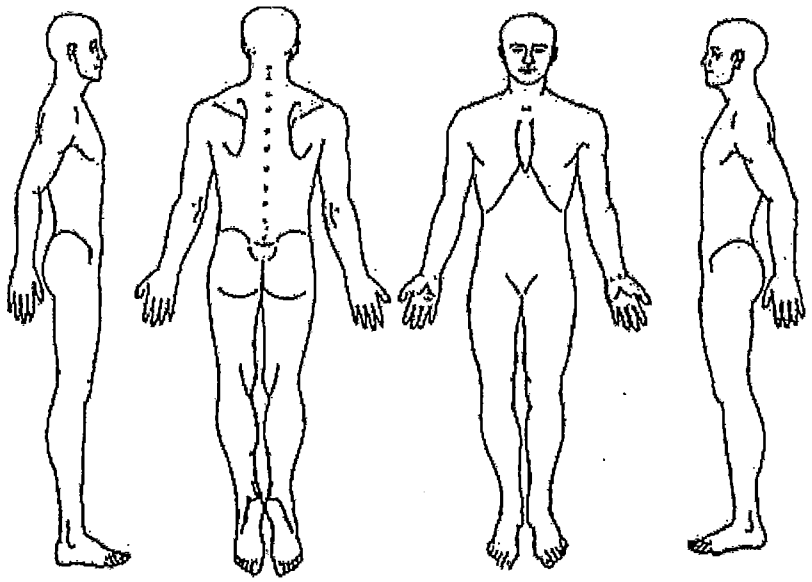
Make sure you enter through the back for our FREE parking

8005 Harford Road, Suite 102, Parkville, MD 21234 ▲ Phone: 410.663.3133 ▲ Fax: 410.663.3089
www.advancedcarept.com

Advanced Care Physical Therapy

Patient Name: _____Age: ____Height: _____Weight:_____
Primary Care Doctor:_____ Referring Doctor:_____
Emergency Contact: _____ Relation _____
Contact's Phone #: _____
Next follow-up doctor's appointment:_____
Please describe your reason for coming in: _____
_____
_____
Date of injury or onset of pain: _____
Did you have a recent surgery:_____ Surgery date:_____
What makes symptoms better:_____
What makes symptoms worse:_____
Have you had an X-Ray or MRI?:_____ Where?:_____
Please rate your pain (0-10, 10 meaning you need to go to the hospital):_____

Please mark your pain with an X:



Do you have any numbness or tingling? Y/N If so, where:_____
Do you have any weakness? Y/N If so, where:_____
Have you had any other treatments for your current condition?_____
_____

Do you use any assistive device? (cane, walker, etc) _____
Do you drive? _____
Do you have stairs at home? _____ If so, how many? _____
Have you fallen in the past year? _____
What activities are you currently unable to perform that you would like to? _____
_____
_____

Medical History

History of infectious disease? (HIV, Hepatitis...) _____
Any Neurological Conditions? (Parkinsons, MS...)_____
Do you have any skin diseases? _____
Do you have Cancer? _____ Type: _____ Status: _____
Do you have a Pacemaker? _____
Are you pregnant or recently given birth? _____

Do you have a history of any of the following conditions?

• High Blood Pressure	Yes/No	• Seizures	Yes/No
• High Cholesterol	Yes/No	• Lyme Disease	Yes/No
• Diabetes	Yes/No	• Heart Attack	Yes/No
• Hepatitis	Yes/No	• COPD	Yes/No
• Osteoporosis	Yes/No	• Asthma	Yes/No
• Depression	Yes/No	• Fibromyalgia	Yes/No
• Vertigo/Dizziness	Yes/No	• Headaches	Yes/No
• Thyroid Condition	Yes/No	• DVT/Blood Clots	Yes/No

Please list any allergies: _____
Do you smoke or chew tobacco? Y/N If so, how much? _____
Do you drink any alcohol? Y/N If so, how much? _____

Occupation: _____

Are you currently working? Y/N If so, are you on modified duty? Y/N

Was/Is your injury work related? _____

Have you recently experienced any of the following?

- Unexplained Weight Loss Y/N _____
- Night Pain Y/N _____
- Unexplained Fatigue Y/N _____
- Numbness or Tingling In Both Legs Y/N _____
- Changes In Bowel or Bladder Function Y/N _____
- Recent Infection Y/N _____
- Shortness Of Breath Y/N _____

Any other important medical history (briefly describe) _____

_____

Please list medications here or provide a copy to the front desk:

- _____ _____
- _____ _____
- _____ _____

Please list any previous surgeries and dates of surgeries:

- _____ _____
- _____ _____
- _____ _____

What do you hope to achieve through therapy? (Goals/Expectations)

1. _____
2. _____
3. _____

Advanced Care Physical Therapy, Inc.
8005 Harford Road
Suite 102
Parkville, MD 21234
410-663-3133

Dear Patient,

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We now offer the following payment options:

__Payment By Cash
__Payment By Check
__Payment By Credit Card
__Automatic Monthly Billing To Your Credit Card
__Guarantee Any Amount Not Covered By Insurance With Your Credit Card

Please make your choice, sign below and return to the office before treatment.

Our office is a fully approved and an accredited user of the Visa and Master Card Health Care Program which will enable you to use your Visa or Master Card to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your credit card on a monthly basis.

If none of the above apply, please see the practice manager, Thank you.

Print your name here and sign below:

X_____

X_____ Date: _____

Advanced Care Physical Therapy, Inc.
8005 Harford Road Suite 102
Parkville, MD 21234
410-663-3133

Patient Name: _____ Date:_____

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

Advanced Care Physical Therapy, Inc.
8005 Harford Road Suite 102
Parkville, MD 21234

If my current policy prohibits direct payment to doctors, 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 services 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 physician, insurance company, adjuster or attorney involved in this case.

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

_____ _____

Signature of Policyholder Witness

Advanced Care Physical Therapy, Inc.

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 described here.

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.
Advanced Care Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. 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 reasons other than your treatment, payment or other related administrative purposes.

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

Advanced Care Physical Therapy, Inc.
Candice Bonner, Practice Manager
8005 Harford Road Suite 102
Parkville, MD 21234
Telephone: (410) 663-3133 Fax: (410) 663-3089

ADVANCED CARE PHYSICAL THERAPY, INC.

Patient Information Consent Form

I have read and fully understand Advanced Care Physical Therapy's Notice of Information Practice. I understand that Advanced Care Physical Therapy may use or disclose my personal health information for the purposes of caring out treatment, obtaining the 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 requests 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 requests to Employee's 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 acknowledgement on the date below.

Patient Signature: _____ Date: _____

ADVANCED CARE
PHYSICAL THERAPY
EST. 1995

There will be a ***$25 cancellation/no show fee*** if you are unable to make your appointment without giving at least 24 hours prior notice.

POLICY:

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. ACPT's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message ***at least 24 hours*** before their appointment time. Notification allows us to better utilize appointments for other patients in need of prompt medical care.

Patient Signature: _____

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