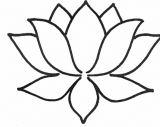


ADVANCE
PHYSICAL THERAPY
Certified Postural Restoration Center

77 South Elliott Road
Chapel Hill, NC 27514



35 Thompson St, Ste 102
Pittsboro, NC 27312

PATIENT INFORMATION

Date: _____

Name: First _____ Last _____ MI _____

Street Address _____ City _____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

Email _____ How did you hear about us? _____

Date of Birth _____ Age _____ Gender: Male / Female

Profession _____ SS# _____

Emergency Contact Name and Relationship: _____

Phone _____

Primary Care MD _____ Referring MD (if different) _____

Next appointment with referring MD _____

Medical Diagnosis/Primary Concern: _____

Date of Onset: _____ Date of Surgery _____ Date of Accident _____

CONSENT FOR TREATMENT

I, the undersigned, give permission to the practitioner/s of Advance Physical Therapy, to administer evaluation and treatment necessary and advisable for my condition. (if a patient is a minor, a parent or guardian must sign) Consent must be signed before we begin treatment.

Consent for Use and Disclosure of Personal Health Information

Date

Name: _____

Date: _____

MEDICAL HISTORY INTAKE FORM

Have you or an immediate family member ever been told you have (please circle and indicate relation i.e. "self", "mother", "brother", etc.)

<i>Allergies</i>	<i>Cirrhosis/liver disease</i>	<i>High Cholesterol</i>
<i>Angina or chest pain</i>	<i>Depression</i>	<i>High Blood Pressure</i>
<i>Anxiety/Panic Attacks</i>	<i>Diabetes</i>	<i>Kidney Disease/Stones</i>
<i>Arthritis</i>	<i>Eating Disorder</i>	<i>Multiple Sclerosis</i>
<i>Asthma or other breathing problems</i>	<i>(Anorexia, Bulimia)</i>	<i>Osteoporosis</i>
<i>Cancer</i>	<i>Headaches</i>	<i>Stroke</i>
<i>Chemical Dependency (Drugs, alcohol)</i>	<i>Heart Attack</i>	<i>Tuberculosis</i>
	<i>Hemophilia or slow healing</i>	<i>Other (please describe)</i>

HAVE YOU EVER HAD (please circle):

<i>Anemia</i>	<i>Hypoglycemia</i>	<i>Rheumatic Fever</i>	<i>Parkinson's</i>
<i>Epilepsy/Seizures</i>	<i>Joint Replacement</i>	<i>Urinary Problems</i>	<i>Peripheral</i>
<i>Fibromyalgia</i>	<i>Polio/post polio</i>	<i>GERD/Ulcers</i>	<i>Vascular Disease</i>
<i>Hepatitis/Jaundice</i>	<i>Skin Problems</i>	<i>Gout</i>	<i>Thyroid problems</i>

FOR WOMEN (please circle)

Endometriosis
Pelvic Inflammatory Disease

Are you pregnant? _____
of pregnancies? _____
live births? _____

FOR MEN (please circle):

Prostate Problems
Genital Pain/Problems

GENERAL HEALTH:

1. I would rate my health as: ***Excellent*** ***Good*** ***Fair*** ***Poor***
2. Please list prescription medications: _____
3. Please list over the counter medications: _____
4. Please list vitamins/supplements: _____
5. Have you been sick in the last 3 weeks? _____ If yes, describe _____
6. Have you noticed any lumps or thick skin or muscle anywhere on your body? _____
7. Do you have any sores that have not healed or any change in size, shape, or color of a wart or mole? _____ If yes, describe _____
8. Do you smoke or chew tobacco? _____ How much per day? _____ # of years? _____
9. I used to smoke/chew but quit. _____ How much per day? _____ # of years? _____
10. I would like to quit smoking/chewing tobacco. Yes No

Financial Policy

This is an agreement between Advance Physical Therapy as creditor, and the patient/debtor named on this form. In this agreement the words 'you', 'your', and 'yours' mean the patient/debtor. The word 'account' means the account that has been established in your name to which charges are made and payments credited. The words 'we', 'us' and 'our' refer to Advance Physical Therapy.

By executing this agreement, you are agreeing to pay for all services that are received.

Payments: Unless other arrangements are approved in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. You agree to pay any portion of the charges not covered by insurance.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Orange County, North Carolina.

Credit History: We are members of the American Credit Bureau. You give us permission to answer questions about your credit experience with us. We have the option to report your account status to the credit bureau.

Waiver of Confidentiality: You understand if this account is submitted to an attorney if we have to litigate in court, or if your past due status is reported to the credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/ authorization by your employer and/or worker's compensation carrier. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney. In addition, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name or responsible party: _____

Signature: _____ Date: _____

Consent For Use and Disclosure of Personal Health Information

I have read and fully understand Advance Physical Therapy's Notice of Information Practices. I understand that Advance 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. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Advance Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Advance physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient's name or responsible party: _____

Signature: _____ Date: _____