



Advanced Center for Physical Therapy, PLC
2114 Angus Road, Suite 240
Charlottesville, VA 22901
Phone: (434) 295-4473
Fax: (434) 295-2691

PATIENT REGISTRATION FOR PHYSICAL THERAPY
(PLEASE PRINT CLEARLY)

Patient Name: _____
First Middle Initial Last

Address: _____
Street City State Zip

Home Phone: (____) _____ **Work Phone:** (____) _____ **Cell Phone:** (____) _____

SSN: _____ - _____ - _____ **Sex:** M F **Birth date:** ____/____/____

EMAIL Address: _____ **How did you hear about us?** _____

Referring Physician: _____ (Phone): (____) _____ **Last Visit:** _____
First Last

Date of next appt with Physician: _____ **Date of Injury:** _____

Primary Physician: same as above -OR-: _____
First Last

Patient Employer: _____ **Patient Occupation:** _____

Circle One: **Full Time** **Part Time** **Unemployed** **Retired** **Student** **Marital Status:** S M D W

Emergency Contact: _____ (____) _____ **Phone:** (____) _____
Relationship

INSURANCE

Policy Holder's Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Policy Holder's SSN: _____ - _____ - _____

Responsible Party (if patient is under 18): _____ **Relationship:** _____
First Middle Initial Last

IF JOB RELATED INJURY

Claim Number: _____ **Name of Insurance Company:** _____

Claim Adjuster/Manager: _____ **Phone Number:** _____

Place of employment at the time of injury: _____ **Phone Number:** _____

IF AN AUTO ACCIDENT INJURY

Was a Police Report Filed? Yes No **Police Report Case Number:** _____

Your Insurance Company Name: _____ **Policy ID Number:** _____

Agent's Name: _____ **Phone #:** _____ **Claim #:** _____

Third Party Insurance Company Name: _____ **Policy ID Number:** _____

Agent's Name: _____ **Phone #:** _____ **Claim #:** _____

Attorney's Name: _____ **Phone #:** _____



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Patient Results Agreement

Your comments are extremely important to us and to others who choose to come to Advanced Center for Physical Therapy to get great results. This form gives us permission to enter your results in our:

- SUCCESS STORY BOOK
NEWSLETTER

Please check the box of your choice.

Patient's Signature

Date

PATIENT PRIVACY CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Further, you permit a copy of this authorization to be used in place of the original.

CONFIDENTIAL COMMUNICATION INFORMATION

Patient's Full Name: _____ DOB: ___/___/___ SS#: ___-___-___

Please choose where we can contact you about your therapy appointments, care and/or billing issues:

Home phone #: _____ Work phone #: _____ Cell phone #: _____

Please choose where we can leave a message about your therapy appointments, care and/or billing issues:

Home Work Cell

Who can we leave a message with? No restrictions

Individuals approved to leave a message with: _____

Do you want the billing information sent to an alternative address? Yes No

If yes, please include full address and phone number: _____
Phone #: _____

Patient's Signature (Parent/Guardian if patient is a minor)

Date

Witness

Date



**ADVANCED CENTER FOR PHYSICAL THERAPY, PLC
FINANCIAL POLICY**

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we want to ensure that you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Co payments and unmet deductibles are due at the time of service. Payment for services when applicable is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, Visa, or Discover. A fee of \$25 will be charged for every returned check. We bill electronically, to expedite payment of claims.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.
4. If this injury is work related, and a Workers Compensation claim has been initiated, you are given 10 visits with no claim number, if after the 10th visit, a claim number has not been received, or your case is denied by WC insurance company or VDOLI, then you are responsible for all of the appointments. We require, on your initial visit, that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number and the date of injury on the registration form.
5. For liability cases, where another party may be responsible, you must provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.
6. Your adherence to the recommended number of treatments is a vital component of your progress with our services. Our office requires a **12-hour notice for cancellation of appointments** and reserves the right to charge you **\$25 without 12 hour notice**; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a \$25.00 charge for a missed appointment without notification to the office. If there is repeated non-compliance with your scheduled appointments, ACPT reserves the right to discontinue care and inform your physician of the fact due to non-compliance with the prescribed rehabilitation order.
7. If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney's fees which we incur plus all court costs. We have the option to report your account to any credit reporting agency such as a credit bureau.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We may contact appropriate family members for medical claims processing purposes. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Authorization for Treatment & Assignment of Medical Benefits

I have read the above policies and agree. I authorize Advanced Center for Physical Therapy, PLC (the Provider) to render to patient physical therapy or other related services (collectively "therapy services") that Provider or patient's treating physician determines may be necessary or advisable. I assign to Provider all Medicare and/or private insurance benefits (primary and secondary) or other benefits to which patient may be entitled for any therapy services rendered on behalf of patient. The information that patient has provided is true and accurate in all respects.

Patient's Name: _____

SIGNATURE: _____
Patient/Legal Representative/Financially responsible Party (if under age of 18)

DATE: _____

ACPT witness: _____

DATE: _____

Copy given to patient: YES _____ NO _____
Updated 6/29/09nt

Patient Name: _____ **Age:** _____

Your condition is: Auto Accident Related Work Related Other _____

Type of Injury/Condition/What happened? _____

Onset/Injury Date: _____ **Type of Surgery & Date:** _____ **Next appt. with Dr:** _____

Occupation: _____

Describe your JOB activities: _____

Does this problem keep you from working? Yes No (If yes, date last worked: _____)

Working restrictions: No Yes If yes, what restrictions? _____

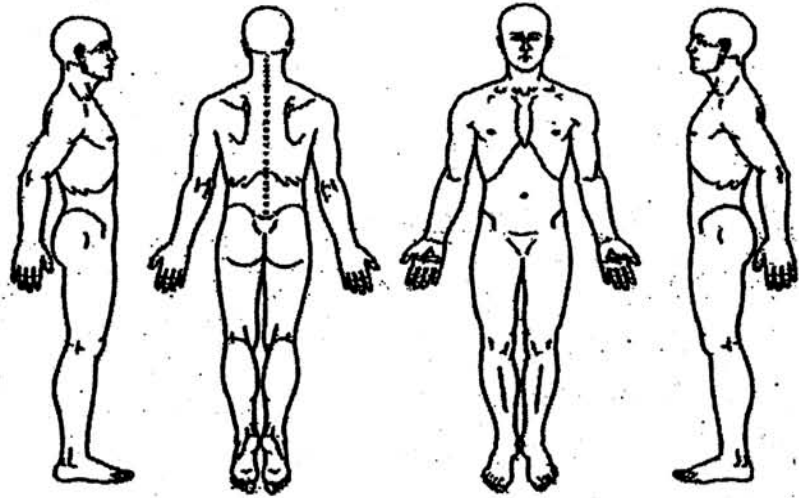
What describes the nature of your symptoms? (Circle all that apply)

Sharp-Stab/ Burning / Aching / Tingling / Numbness / Throb / Cramp / Shoot/ Sore / Other _____

Rate your pain (1=minimal, 10=severe): My pain is: Constant Comes & Goes

At its worst: 1 2 3 4 5 6 7 8 9 10 / **At its best:** 1 2 3 4 5 6 7 8 9 10

Pain scale today: 1 2 3 4 5 6 7 8 9 10



Please mark the area(s) of concern

Activities

Check what makes your symptoms WORSE:

- Sitting Standing Bending
- Lifting Lying Down Walking
- Coughing Sneezing Exercise
- Other: _____

Check what makes your symptoms BETTER:

- Sitting Standing Bending
- Lifting Lying Down Walking
- Heat/Cold Exercise
- Medications _____
- Other: _____

Circle what activities you are ABLE to do:	Going up/down stairs	Yes / one at a time / No
Dressing	Yes / No	Getting in/out of a car
Toileting	Yes / No	Getting up/down from furniture
Fixing Meals	Yes / No	Self Care (bathing, brushing teeth, etc.)
Reaching/Bending	Yes / No	Recreational Activities (sports, hiking, etc)
Housework	Yes / No	

(Please turn over to complete the other side.)

Do you exercise regularly? Yes No) How frequent? (Circle one) 1 , 2 , 3 , more than 3 x/week

If yes, describe the exercise: _____

What do you hope to get out of your treatment? _____

Any other goals? _____

Is there anything else you would like to include or ask your physical therapist? _____

Check other treatments you have had for this same condition:

_____ Physical Therapy _____ Chiropractic _____ Other: _____

Please list prescription or over the counter medication you routinely take:

Name of Medication	What is it for?	Name of Medication	What is it for?
1.		4.	
2.		5.	
3.		6.	

Have you recently noted: (Check all that apply)

- Weight loss/gain
- Nausea/vomiting
- Fatigue
- Pregnant
- Dizziness
- Weakness
- Headaches
- Insomnia
- Fever/chills/sweats
- Pain at night
- Numbness/tingling
- Loss of consciousness/fainting
- Cramps in legs while walking
- Change in vision or hearing

Do you have now or have you ever had any of the following?

- High blood pressure
 - Blood clot
 - Pacemaker
 - Irregular heartbeat
 - Aortic aneurysm
 - Easy bleeding
 - Stroke or TIA
 - Heart attack or angina
 - Poor circulation (leg/ankle swelling)
 - Arthritis
 - Rheumatoid arthritis
 - Osteoporosis
 - Diabetes
 - Seizures
 - Cancer
 - HIV/AIDS
 - Migraine Headaches
 - Ulcers in stomach or intestines
 - Prolonged prednisone use
 - Emphysema or asthma
 - Depression
 - Addiction to alcohol
 - Addiction to other drugs
 - Anxiety disorder
 - Other mental illness
 - Bowel problems
 - Severe head injury
 - Motor Vehicle accident
- Sprains/Strains (If yes, where? _____)
- Broken bones (If yes, where? _____)
- MRI XRAY OTHER: _____

List previous surgeries: _____

Patient/Legal Guardian Signature

Date

Reviewed by Physical Therapist

Date