

# Patient Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_ Suffix \_\_\_\_\_

Social Security # \_\_\_\_\_ Gender \_\_\_\_\_ Birth Date \_\_\_\_\_

Marital Status \_\_\_\_\_ Student Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Which is the primary number? Home / Cell / Work

Notify by Email? yes or no Notify by text? Yes or no

Emergency Contact Name \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured information same as patient? Yes \_\_\_ No \_\_\_ If no, name of policy holder \_\_\_\_\_

Patient relationship to insured: \_\_\_\_\_ Policy holder date of birth: \_\_\_\_\_

Referred by doctor: \_\_\_\_\_ Primary Care doctor: \_\_\_\_\_

Date of onset of injury \_\_\_\_\_ Is this a work related injury/condition? Yes \_\_\_ No \_\_\_

If yes, date of injury: \_\_\_\_\_ Where: \_\_\_\_\_ How: \_\_\_\_\_

Did you report injury to your employer or supervisor? Yes \_\_\_\_\_ No \_\_\_\_\_

Is this related to an auto accident? Yes \_\_\_ No \_\_\_ If yes, date of injury: \_\_\_\_\_

Insurance claim information: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

Employer address: \_\_\_\_\_ Phone # \_\_\_\_\_

Have you had previous therapy for your present condition? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, where: \_\_\_\_\_ When: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

The above information is correct to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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## For Office Use Only:

Patient co-pay \_\_\_\_\_ Insurance pays % \_\_\_\_\_ Precert/Auth required? \_\_\_\_\_

Deductible amt \$ \_\_\_\_\_ Deductible Met \$ \_\_\_\_\_ Pre-existing clause? \_\_\_\_\_

Visits allowed per year? \_\_\_\_\_ Amount allowed per year \$ \_\_\_\_\_ Effective date \_\_\_\_\_

Visits allowed per injury? \_\_\_\_\_ Amount allowed per injury \$ \_\_\_\_\_ Expiration date \_\_\_\_\_

Out of pocket per year? \_\_\_\_\_ Out of pocket paid to date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

## MEDICAL HISTORY

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	Parkinsons	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No		
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No		

Describe any other conditions or precautions:

### Fall History

Injury as a result of a fall in the past year?  Yes  No      Date of Fall: \_\_\_\_\_

Two or more falls in the last year?  Yes  No      Dates of Falls: \_\_\_\_\_

### Surgical History

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

### Current Medications

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

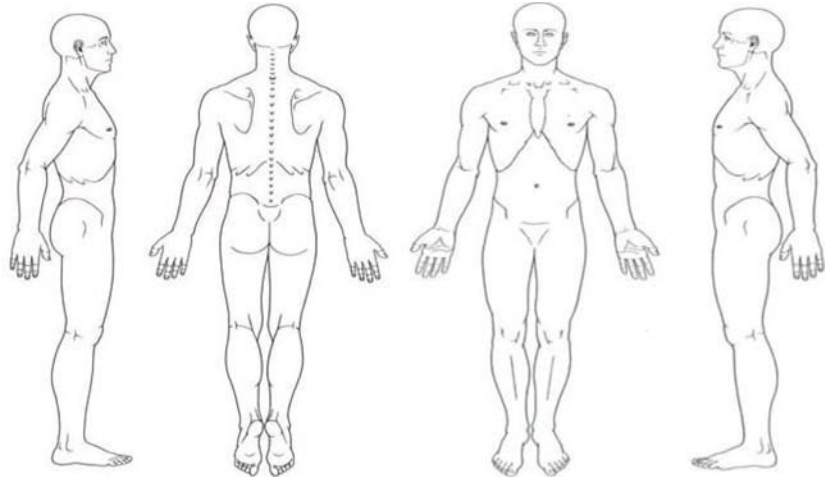
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



## 3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

## 4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

## 5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all      ② A little bit      ③ Moderately      ④ Quite a bit      ⑤ Extremely

## 6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

① All of the time      ② Most of the time      ③ Some of the time      ④ A little of the time      ⑤ None of the time

## 7. In general would you say your overall health right now is...

① Excellent      ② Very Good      ③ Good      ④ Fair      ⑤ Poor

## 8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

\_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

## 10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## CONSENT TO TREAT /FINANCIAL POLICY FORM

### CONSENT TO TREAT

I \_\_\_\_\_ hereby consent to physical therapy treatment.  
(Please print)

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Patient/Guardian (if minor) Signature

Date

### Financial Policy

I authorize the assignment of benefits for my insurance to pay Advanced Physical Therapy of Laguna-Viejo directly. I understand that I am ultimately responsible for the charges incurred for my treatment by Advanced Physical Therapy. I understand that the staff of Advanced Physical Therapy will help in billing my insurance company for payment. It is my responsibility to follow-up on any claim submitted if payment is not received in a reasonable amount of time.

I authorize the release of any and all medical information necessary to determine liability for payment and to obtain reimbursement including medical records to any person or corporation, which is or may be liable for all or any portion of charges. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare claims.

**I understand there is a \$25.00 fee for any Cancellations and / or No Shows of appointments without 24 hour notification.**

I have read and understand all of the information above, and I have completed the information to the best of my knowledge.

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Patient/Guardian (if minor) Signature

Date

### CO-PAYMENT DEDUCTIBLE AGREEMENT

**I also understand that I am responsible for any co-payment and /or deductible associated with my insurance policy. I understand that I will be expected to pay my co-payment amount at time of treatment.**

My insurance benefits have been verified and it is **estimated** that my co-pay/co-insurance amount

at time of visit is \_\_\_\_\_% of allowed amount or \$\_\_\_\_\_ per visit. My insurance has indicated that I still owe a portion of my deductible. Deductible amount not met is \$\_\_\_\_\_. If I have not met my deductible requirement I agree to make payments toward meeting my deductible. I understand the co-pay/co-ins. amount is an estimate and I may be responsible for additional amount not paid by my insurance.

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Patient/Guardian (if minor) Signature

Date



Patient \_\_\_\_\_

Dear Patient,

Effective January 1, 2012 Medicare imposed limits on benefits paid for outpatient Physical Therapy services provided in private practice setting. Medicare has limited coverage to \$1,880.00 per calendar year. This amount is divided between Medicare payment and patient payment. Medicare will pay \$1,504.00 and your responsibility would be \$376.00 if all benefits are used. If you maintain a secondary payer the \$376.00 may be covered. We have estimated that this cap will allow you to receive up to 10-12 visits in our facility. You will be informed that your benefit is ending at least one visit prior to reaching the visit limit.

The benefit for Physical Therapy is cumulative for the year. This includes any Physical Therapy or Speech Therapy services provided to you this year. If you have exhausted your benefits with another provider or with us earlier this year you will be responsible for any part of your bill in excess of the \$1,880.00 limit. Medicare has informed us that they may not be able to verify your use of benefits. It is therefore your responsibility to determine if you have Physical Therapy benefits available for your treatment with us.

This coverage limit pertains to independent Physical Therapy offices. You may choose to receive additional treatment at a hospital or continue Physical Therapy with us on a self-pay basis if continued treatment is indicated.

Please choose **one** of the following statements:

\_\_\_\_\_ I **have** received Physical Therapy or Speech Therapy treatment in a non-hospital setting this year.

\_\_\_\_\_ I **have not** received Physical Therapy or Speech Therapy treatment in a non-hospital setting this year.

\_\_\_\_\_ I understand that if I previously used my Medicare benefits for Physical  
(initial) Therapy or Speech Therapy treatment that I will be responsible for treatment provided in excess of my annual benefit.

\_\_\_\_\_ If you have had **Home Health Care** over the past 60 days Medicare may deny  
(initial) payment for Physical Therapy

By signing below I am stating that I understand the limits of my Medicare coverage for Physical therapy services and assume financial responsibility for non-covered care.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date