Advanced Therapy Solutions

Patient Name: First_____ Middle Initial _____

Last:_____

Address_____

City_____State_____Zip_____

Social Security #_____-_____-_____Date of Birth_____/_____/_____

Sex: M or F

Drivers License #_____ Issuing State:_____

Marital Status: Single Married Divorced Widowed

Email Address:_____@_____

(Your email is used for compliance with federal insurance program directives and alerts that are important for your care while at Advanced Therapy Solutions. It will never be given to third parties for marketing purposes.)

Home Phone #_____Cell Phone #_____

Employer_____Phone #_____

Address_____City_____State_____Zip_____

In case of emergency

Notify_____Phone #_____

_____

For Dependants and Minor Patients:

Insured/Guardian_____Relationship_____

Address_____City_____State_____Zip_____

Home Phone:_____Social Security #:_____-_____-_____ Sex: M or F

Drivers License #_____Date of Birth_____/_____/_____

Health Information

Please circle: Are you-- right handed or left handed.

Date of last TX Health Steps: _____/_____/_____ (For Medicaid Age 20 and below only)

Date of onset/worsening of current problem (estimation acceptable): _____/_____/_____

Did you have surgery for the current problem? Yes or No Date: _____/_____/_____

Is this a work related injury? Yes or No

If yes, Date of Injury?_____

Worker's Comp Adjustor_____

Worker's Comp Claim #_____

Is this an Auto related injury? Yes or No

If yes, Date of accident?_____

Attorney_____Phone:_____

Have you had PT for this condition? Yes or No

If yes, Previous PT Provider_____

If covered under Medicare or Medicare replacement, answer the following questions:

Are you currently receiving Home Health or Provider Services? Yes or No

If yes, from whom?_____

Do you live in a nursing home? Yes or No

If yes, location?_____

Are you covered under Black Lung Disease? Yes or No

Are you covered by End Stage Renal Disease? Yes or No

CURRENT CONDITION(S) CHIEF COMPLAINT(S)

Have you ever had the problem(s) before? Yes or No

If yes, what did you do for the problem(s)? _____

Did the problem get better?_____

Date & Location of PT _____

How are you taking care of the problem now?_____

What are your goals for physical therapy? _____

Date of next appointment with the Dr. who ordered therapy? _____

Name of Dr. ordering therapy?_____

Are you seeing anyone else for the problem(S)? Yes or No.

If yes whom? _____

SURGICAL HISTORY

HAVE YOU EVER HAD SURGERY? IF YES, PLEASE DESCRIBE AND INCLUDE DATES:_____

_____

_____

FOR WOMEN ONLY- ARE YOU PREGRANT OR THINK YOU MIGHT BE? YES OR NO

SOCIAL HISTORY

Any cultural or religious beliefs that might affect care?_____

Employment (please circle)

Working full time outside the home	Homemaker
Working full time from the home	Student
Working part time outside the home	Retired
Working part time inside the home	Unemployed

Occupation (what type of work do you perform)_____

Please have your insurance card(s) and driver's license available for us to make copies.

Assignment of insurance Benefits: I assign all medical benefits to which I am entitled to be paid directly to Advanced Therapy Solutions. 1530 Springhill Rd. Suite B. Jasper Texas 75951. A photocopy of this assignment is to be considered as valid as the original. Treatment Consent: I hereby give consent for physical therapy to be administered to me or minor patient by persons in this office in acceptable, professional standards. Financial Agreement : I understand that all payments designated as "the patient's responsibility" such as co insurance, co-pays, and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed my responsibility within the statement due date.

☐ I do ☐ do not agree to received text messages for reminders of my appointments and other matters pertinent to my care.

☐ I do ☐ do not agree to received e-mails pertinent to my care and treatment at Advanced Therapy Solutions.

_____ _____

Patient or Guardian Signature Date

Rev. 01212020

PHOTO RELEASE

I hereby give permission to Advanced Therapy Solutions to use photographs of_____ (Print Name of Patient) for publication of any book, advertisement, pamphlet, electronic medium or other material which may be written, published, produced or copyrighted by them or parties of interest. I also release them from any claims and all liability for damages of every kind now existing or which may arise from the use of these photographs.

I HAVE READ AND UNDERSTAND THIS RELEASE.

_____ DATE

_____SIGNATURE OF PATIENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Advanced Therapy Solutions. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Advanced Therapy Solutions to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature