Atlantic Physical Therapy Center

www.ATLANTICPTCENTER.com

Referral Information

Past Patient: ☐ YES ☐ NO

WHOM MAY WE THANK FOR REFERRING YOU TO US?

Patient Information

Email Address for APTC Announcements:

Patient Name: (First, MI, Last, - Sr., Jr., etc) | SS #: - -

Address: | City | State: | Zip Code:

Telephone: | Date of Birth (mm-dd-yyyy) | Sex: ☐ M ☐ F | Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Date of Injury / Onset Date | Auto Related: ☐ Yes - State? _____ ☐ No | Work Related: ☐ Yes ☐ No | **Adjustor Name & Telephone #:** Claim # _____

If Workers Comp, was accident with present Employer?
☐ Yes ☐ No If No, who was employer? _____
Occupation: _____

If Auto Accident: Date of Accident: ____ / ____ / ____
Type of Accident: Driver / Passenger / Pedestrian / Job / Fall / Other

Do you have Medicare Insurance Coverage? ☐ **No** ☐ **Yes** Are you currently receiving Home Health Services? ☐ No ☐ Yes

Primary Insurance Information (If you are the policy holder – you may **skip** this section)

Name of Insurance Company: | Policy or Claim #: | Group # / Policy Holders Employer:

Policy Holder Name: | Date of Birth: | Social Security #

Policy Holder Address: | Policy Holders Phone #: | **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Information (Backup if Auto is Primary)

Name of Insurance Company: | Policy or Claim #: | Group # / Policy Holders Employer:

Policy Holder Name: | Date of Birth: | Social Security #

Policy Holder Address: | Policy Holders Phone #: | **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Employer Information

Employer Name: | Employer Phone #: | Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student

Address: | City | State: | Zip Code:

Emergency Contact Information

Contact Name: | Phone # | Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Financial Policy

As the patient, you are responsible for knowing the policies and procedures of your insurance plan, including pre-certification requirements, limitations, maximum benefits, co-payments, etc. As a courtesy, we will submit all primary and secondary insurance billing. Any remaining balance such as co-insurance, deductible, etc. is your responsibility. If you have any questions please speak to a member of our office staff.

I _____authorize Atlantic Physical Therapy Center to treat me as per my doctor's prescription and to release to my insurance company/Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Signature: _____ Date: _____

Atlantic Physical Therapy Center Pain Profile

1. What activities increase your pain: _____

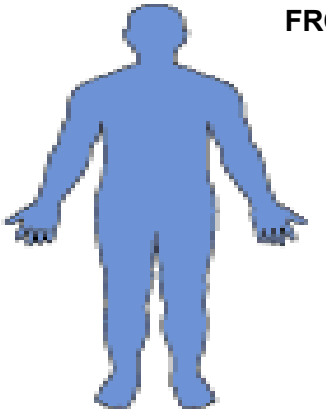
2. What activities decrease your pain: _____

3. Are you presently working? Yes No Occupation: _____

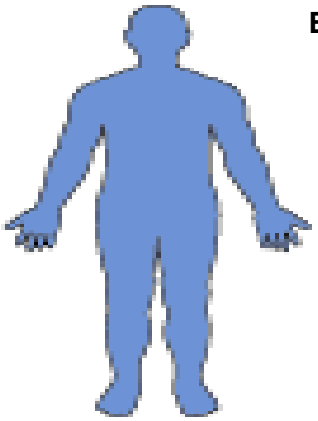
4. What do you hope to accomplish with PT? _____

Please shade/circle in the areas that correspond to your pain or numbness

FRONT



BACK



Please Rate Pain

0
1
2
3
4
5
6
7
8
9
10

Injury Information

Work Related Injury Athletic Injury Motor Vehicle Accident Other: _____

Date of Injury / Surgery _____ Date of next doctor's visit _____

Have you ever had these symptoms before? _____

Please check any of the following that apply to you:

_____ Diabetes
_____ Chest pain / Angina
_____ High Blood Pressure
_____ Heart Disease
_____ Heart Attack
_____ Heart Palpitations
_____ Pacemaker
_____ Headaches
_____ Kidney Problems
_____ Cancer
_____ Bowel / Bladder Abnormalities
_____ Liver / Gall Bladder Abnormalities
_____ Asthma / Breathing Difficulties
_____ Smoking

_____ Allergies to Aspirin
_____ Allergies to Heat
_____ Allergies to Cold
_____ Other Allergies
_____ Hernia
_____ Seizures
_____ Metal Implants
_____ Dizziness / Fainting
_____ Recent Fractures
_____ Surgeries
_____ Skin Abnormalities
_____ Ringing in your Ears
_____ Nausea / Vomiting
_____ Special Diet Guidelines

Is there any information in your past medical history that we should know about?

_____

Are you presently taking any medication? _____ if yes, please list medications:

_____

Patient Signature _____ Date _____

ATLANTIC physical therapy center

Official Physical Therapy Provider for the Lakewood BlueClaws

HIPAA PRIVACY POLICY NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Disclose health information in order to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.

Disclose your health information in order to receive payment for the services we provide to you.

Disclose your health information for normal healthcare operations such as quality assessments and physician certifications.

PATIENT RIGHTS REGARDING MEDICAL INFORMATION

The Right to Inspect and Copy Your Information: You may review and copy your medical records and information.

The Right to Amend: You may ask that we amend your health information if you believe that your information is incomplete or incorrect.

The Right to Request Restrictions: You may request a restriction or limitation on how and what health information we disclose regarding you for treatment, payment of health operations or to your family or care-givers.

The Right to Confidential Communications: You may request that we communicate with you about medical matters in a certain format or a specific location.

The Right to Receive a Copy of this Notice: You may request and receive a copy of this notice (or our current notice) at any time by contacting this organization.

_____ _____

Print Patient Name Relationship to Patient

_____ _____

Signature Date

PATIENT NAME: _____ **ID#:** _____ **DATE:** _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS – INITIAL VISIT

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: _____