



**A P E X**  
PHYSICAL THERAPY

# NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date: \_\_\_\_\_

Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
(M.I.) \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F

Drivers Lic #: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Referring Physician: _____		
Referring Dr. Address: _____	Phone Number _____	
City: _____	State _____	Zip _____

Status Married / Single / Divorced / Separated / Widowed	Student No / Full-Time / Part-Time
Employment Full-Time / Part-Time / None / Retired	Employer: _____

Email Address: _____
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Injury Type: Work Auto Home Other: _____	Date of Injury: _____
If Work Comp Claim: Employer at time of Injury: _____	Phone: _____
Attorney Involved? Yes / No Attorney Name: _____	Telephone #: _____

Primary Insurance: _____	Subscriber Name: _____		
Relationship to Patient: _____	Subscriber: _____	ID # _____	Date of Birth _____
Group/Policy # _____			
Secondary Insurance: _____	Subscriber Name: _____		
Relationship to Patient: _____	Subscriber: _____	ID # _____	Date of Birth _____
Group/Policy # _____			

*I hereby give lifetime authorization for payment of insurance benefits to be made directly to Apex Physical Therapy and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure payment of benefits. I understand that I have the right to choose my Physical Therapy provider and have chosen this facility and hereby give my consent to treatment. I further agree that a photocopy of this agreement shall be as valid as the original.*

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

## Medical History Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

What is your main problem? \_\_\_\_\_

Have you had any of the following? (please circle)

Heart disease	Yes	No	High blood pressure	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Kidney disease	Yes	No	Tuberculosis	Yes	No

Please list any other serious illnesses \_\_\_\_\_ Age of onset \_\_\_\_\_

Please list any serious injuries \_\_\_\_\_

Please list any significant surgeries or hospitalizations and why? \_\_\_\_\_

Are you allergic to any foods or medication? Yes No If yes, please list \_\_\_\_\_

Are you allergic to latex? Yes No

Have you ever had hay fever or asthma? Yes No

Please list all medications you are currently taking \_\_\_\_\_

Does or has anyone in your family have or had the following? (please circle)

Heart disease	Yes	No	High blood pressure	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Kidney disease	Yes	No	Tuberculosis	Yes	No
Stroke	Yes	No	Mental retardation	Yes	No
Brain disease	Yes	No	Spinal cord disease	Yes	No

Need to explain? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Pk/day \_\_\_\_\_ Do you use drugs or alcohol? \_\_\_\_\_ Drinks/wk \_\_\_\_\_

Have you had any of the following? (please circle)

Head injury	Yes	No	Arthritis in neck	Yes	No
Headache	Yes	No	Arthritis in back	Yes	No
Blurred vision	Yes	No	Neck injury	Yes	No
Double vision	Yes	No	Back injury	Yes	No
Loss of vision	Yes	No	Disc problems	Yes	No
Fainting	Yes	No	Tremor or shaking	Yes	No
Dizziness	Yes	No	Seizures	Yes	No
Speech difficulty	Yes	No	Convulsions	Yes	No
Trouble walking	Yes	No	Blackouts	Yes	No
Loss of balance	Yes	No	Meningitis	Yes	No
Frequent falls	Yes	No	Encephalitis	Yes	No
Weakness in arms	Yes	No	Frequent Infections	Yes	No
Weakness in legs	Yes	No	Loss of weight	Yes	No
Poor coordination	Yes	No	Night sweats	Yes	No
Swelling of legs	Yes	No	Bladder problems	Yes	No
Cough	Yes	No	Bowel problems	Yes	No
Chest pain	Yes	No	Black stool	Yes	No
Shortness of breath	Yes	No	Bloody stool	Yes	No



# PRIVACY & SECURITY

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APEX PHYSICAL THERAPY AND ORTHOPEDIC REHABILITATION  
COMPLIANCE PROGRAM  
PRIVACY AND SECURITY COMPLIANCE PLAN  
PRIVACY & SECURITY NOTICE

Apex Physical Therapy and Rehabilitation, in compliance with certain laws, has taken reasonable and comprehensive steps towards the protection of the privacy and security of your personal health information. Such information may include oral, written, telephone, facsimile and/or other electronic communication of protected health information (PHI).

Complete information regarding Privacy and Security Practices is available to all patients upon individual request and such information is entitled "Statement of Privacy and Security Practices".

Individual Patient Rights: You have rights with respect to the following:

- § To read and understand this privacy and security notice prior to treatment
- § To request a copy of "Statement of Privacy and Security Practices"
- § To expect that all protected health information be utilized only for the following purposes:
  - Treatment (including contacting you with regards to appointment and other treatment related communication)
  - Payment
  - Health care operations
  - Mailing or other communication with you in the form of announcements and/or newsletters
- § To request a copy of your personal health information
- § To request revision of inaccuracies in your personal health information
- § To restrict how your personal health information is used and disclosed except as noted above

Further Information/Concerns: Please express any concerns you may have regarding any violation of your privacy rights, and other privacy and security issues to the Apex Physical Therapy and Orthopedic Rehabilitation Compliance Officer. Any concerns reported will not result in retaliation or retribution.

Compliance Officer: Angie Myers  
141 S. English Station Road, Suite 207  
Louisville, KY 40245  
[apexpt@bellsouth.net](mailto:apexpt@bellsouth.net)  
502.245.1136

You also have the right to report any concerns regarding your privacy rights to the Secretary of the US Health and Human Services Department. The Department can be contacted at <http://www.hhs.gov/ocr/hipaa>.

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**Patient / Guardian / Personal Representative Signature**

**Date**

Revised: 8/17/05



# OFFICE POLICY

**CONSENT FOR TREATMENT OF A MINOR:** As parent and/or legal guardian, I authorize Apex Physical Therapy & Orthopedic Rehabilitation to treat \_\_\_\_\_ (minor's name) while I am not present.

**CONSENT FOR CARE & TREATMENT:** Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for Apex Physical Therapy & Rehabilitation to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Apex Physical Therapy & Rehabilitation to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

**WORKERS' COMPENSATION CLAIMS:** If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

**CANCELLATION & NO-SHOW POLICY:** We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is \$25 for a physical therapy visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. Any future appointments may be automatically cancelled and 2 "no show" appointments may result in discharge from physical therapy.

**NON-SUFFICIENT FUNDS:** Checks returned for Non-Sufficient Funds may be subject to a \$25 processing fee.

\_\_\_\_\_  
**Patient/Guardian/Responsible Party Signature**

\_\_\_\_\_  
**Date**

**FINANCIAL POLICY:** We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Co-Pay	Co-Insurance
Estimated Co-Pay \$ _____/visit Deductible \$ _____/year  <input type="checkbox"/> Will pay each visit <input type="checkbox"/> Will pay weekly in advance	Estimated Co-Insurance \$ _____/visit Deductible \$ _____/year  (You will be billed for your co-insurance & deductible)

The above financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

\_\_\_\_\_  
**Patient/Guardian/Responsible Party Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Clinic Representative**

\_\_\_\_\_  
**Date**