ADVANTAGE
ORTHOPEDIC PERFORMANCE & TRAINING

PERSONAL INFORMATION

PLEASE COMPLETE ALL SECTIONS		
NAME	HOME PHONE	CELL PHONE / CARRIER
ADDRESS	CITY	ZIP CODE
EMPLOYER	WORK PHONE	
BIRTHDATE	EMAIL ADDRESS	SEX
MARITAL STATUS	REFERRING PHYSICIAN:	
SOCIAL SECURITY NUMBER	PREFERRED METHOD FOR NOTIFICATION OF APPOINTMENTS: ____EMAIL ____TEXT MESSAGE	
EMERGENCY CONTACT NAME	PHONE	RELATIONSHIP

INSURANCE INFORMATION

If we are filing with your general health insurance and you have provided a copy of your insurance card, you do not need to fill out the following section; however, if your injury was due to a motor vehicle accident or a worker's comp injury, the following section is required.

INSURANCE COMPANY	PHONE NUMBER	
ADJUSTOR'S NAME	EXTENSION NUMBER	
BILLING ADDRESS	CITY	ZIP
CLAIM NUMBER	DATE OF INJURY	
PLACE OF ACCIDENT	IS THIS WORK RELATED?	

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify AOPT of any changes in the above information.

_____ _____
SIGNATURE DATE

_____ _____
PARENT OR GUARDIAN (IF MINOR) DATE

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MEDICAL HISTORY

1. **What are you being seen for today?** _____
2. **When do you return to see your doctor?** _____
3. **When was the onset of your symptoms and/or injury:** _____/_____/_____
4. Has a physician ever warned you against exercise: ☐ yes ☐ no
   If yes, please explain: _____
6. Are you currently engaged in any form of exercise: ☐ yes ☐ no
   If yes, please explain: _____
7. Are you currently working full duty: ☐ yes ☐ no
   If no, please list any limitations: _____

   If you are not working due to your injury, when do you anticipate returning to work: _____/_____/_____

8. **Have you ever been diagnosed by a physician with any of the following**:

☐ Asthma/ COPD	☐ Anxiety Depression	☐ Arthritis (OA or RA)	☐ Anxiety/ Depression
☐ Blood Clot	☐ Cancer	☐ Cholesterol	☐ Diabetes 1 or 2
☐ Epilepsy/ Seizures	☐ Fatigue (chronic)	☐ Fibromyalgia	☐ Heart Disease
☐ High Blood Pressure	☐ HIV, Hepatitis	☐ Kidney/ Liver Issues	☐ Low Blood Sugar
☐ Nausea/ Vomiting	☐ Osteoporosis/ penia	☐ Pacemaker	☐ Pain Pump Implant
☐ Thyroid (low or high)	☐ Spinal Stimulator	☐ Defibrillator Implant	☐ Recent Fall
☐ Spinal Fusion	☐ Total Hip Replaced	☐ Total Knee Replaced	☐ Hysterectomy
☐ Total Shoulder or Rotator Cuff Repair		☐ Gallbladder removed	☐ Mastectomy
☐ Numbness/ Tingling in Arms/ Hands, Legs/ Feet		☐ Spinal Discectomy or Laminectomy	

9. **Have you experienced any of the following symptoms in the past month?**

☐ Dizziness or fainting	☐ Illness or fever	☐ Night Sweats
☐ Abdominal or chest pain	☐ Severe Fatigue	☐ Nausea/ Vomiting
☐ Unexplained Weight Loss	☐ Unexplained Weight Gain	☐ Blurred or Double Vision
☐ Facial Dryness	☐ Weakness in the Arms/ Legs	☐ Difficulty Swallowing
☐ Recent Fall- Head/ Neck Injury	☐ Numbness/ Tingling in Face, Tongue	
☐ Headache (not “typical” headache, but severe “unlike any before”)		☐ Sore Throat
☐ Nausea/ Vomiting	☐ Drooping Eye Lid	☐ Difficulty Swallowing
☐ Shortness of Breath		

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10. **Are you pregnant:** ☐ yes ☐ no

11. **Please list any medical conditions/ surgeries not mentioned above:**

_____

_____

_____

_____

12. Please list all current medications:

_____

_____

_____

_____

13. **Have you ever been treated by a Physical Therapist for this injury:** ☐ yes ☐ no

If yes, where and when: _____

14. **Are you undergoing, or have you undergone any other treatment for this injury:** ☐ yes ☐ no

If yes, please explain:

_____

_____

15. Height: _____ Weight: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____

SIGNATURE DATE PLEASE PRINT NAME

CONSENT FOR TREATMENT:

I hereby give my permission for E&R Enterprises, PLLC, dba AOPT to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time

_____ _____

SIGNATURE DATE

CONSENT TO RELEASE/ OBTAIN MEDICAL INFORMATION:

Permission is hereby granted to E&R Enterprises, PLLC dba AOPT to release any and all pertinent PHI information to me, my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. **Permission is hereby granted to any facility where I have previously been treated to release medical records to E&R Enterprises, PLLC dba AOPT**.

_____ _____
SIGNATURE DATE

(this section is if you want to allow someone else access to your medical records)

I also authorize_____, who is known to me by my _____with a DOB of: ___/___/_____ allowable access to any and all of my medical record protected by E&R Enterprises, PLLC dba AOPT, and if I so choose to restrict this access, I grant the aforementioned individual access to only the following information:_____
_____.

It is understood that this access is ***valid for 1 year*** and after that point any requests for protected Health Information (PHI) will need to be accompanied by a newly signed release.

_____ _____
SIGNATURE DATE

AUTHORIZATION FOR PAYMENT OF BENEFITS:

I authorize E&R Enterprises, PLLC dba AOPT to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although E&R Enterprises, PLLC dba AOPT will help verify and assist me in understanding my benefits, it is ultimately my responsibility and **I will not hold E&R Enterprises, PLLC dba AOPT responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me**.

_____ _____
SIGNATURE DATE

MEDICARE PATIENTS ONLY:

I authorize payment of Medicare benefits to E&R Enterprises, PLLC DBA AOPT for services rendered, and I authorize the release of medical information to CMS (Centers for Medicare and Medicaid Services) and/or its agents.

_____ _____
SIGNATURE DATE

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CANCELLATION / NO-SHOW POLICIES

The no-show/cancellation policy is enforced for the following reasons:

1. We rely heavily on our schedule to maintain a high standard of care.
2. By giving appropriate notice to the facility, we are able to offer your appointment slot to other patients.
3. Repeated cancellations will slow your progress and likely prevent you from experiencing optimal outcomes from treatment.

NO-SHOW POLICY

If you do not cancel your appointment in accordance with the cancellation policy below, and/or fail to show for your scheduled appointment, **a $25 no-show fee** will be charged to your account. The fee will not be waived for any reason, so please do not ask.

CANCELLATION POLICY

Failure to cancel your appointment 24 hours in advance, with the exception of emergencies and occasional illness will result in a fee being charged to your account.

REPEATED CANCELLATIONS

Your therapist will recommend a frequency of treatment based on your specific needs. Optimal outcomes from treatment can only be achieved if you take responsibility in your care and are compliant with the therapist's recommendations. Repeated cancellations may result in you being discharged for noncompliance.

These policies are strictly enforced to assure you receive the care you deserve and achieve your goal of a pain-free, active lifestyle. We pride ourselves in providing the highest quality of care possible. Please help us maintain this level of care by making your time here a priority.

A copy of these policies will be provided upon request.

_____ _____

Name Date

AOPT
NOTICE OF PRIVACY PRACTICES
Updated January 1, 20022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to E&R Enterprises, PLLC DBA AOPT and its entities. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Advantage Physical Therapy. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Owner(s), AOPT, 175 W Lowry. Ln. Ste 112, Lexington, KY 40503.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke the authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosure for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and other professionals involved in your care will use information in your medical record and information you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Options: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation, and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved in Your Care: With your written agreement, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in carding for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or

organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to the Owner(s), AOPT, 175 W. Lowry Ln. Ste. 112, Lexington, KY 40503.

Other Uses and Disclosures:
We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls
- To your employer when we have provided healthcare to you at the request of your employer
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings
- Court or administrative ordered subpoena or discovery request
- To law enforcement officials as required by law to report wounds and injuries and crime
- If you are a member of the military, we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU MAY HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

Access to Your Personal Health Information
You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the Office Manager. You are entitled to one free copy of your personal health information. If you request additional copies, you may be charged a nominal fee for copying and postage.

Amendments to Your Personal Health Information
You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments, but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the Owner(s).

Accounting for Disclosures of Your Personal Health Information
You have the right to receive an accounting of certain disclosures made by us of your personal health information after October 12, 2013. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the Owner(s). The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or healthcare operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is

appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such notice to the Owner(s).

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing to the Owner(s), AOPT, 175 W. Lowry Ln. Ste. 112, Lexington, KY 40503. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact the Owner(s), AOPT, 175 W. Lowry Ln. Ste. 112, Lexington, KY 40503; 859.263.8080.

_____ _____

PATIENT (or representative) SIGNATURE DATE