A Step Ahead
Physical Therapy

PATIENT INFORMATION

Last Name: ____________________________ First Name: ______________________ Middle Initial: ________

Preferred Name: ___________________ Gender: ☐Male ☐Female Marital Status: ___________

Date of Birth: _____/______/_____ Age: _______

Street Address: ____

City: ____ State: _______ Zip: ____________

Home Phone: ___________________________________ Cell phone: ______________________________________

Email Address: ____

REMINDER METHOD

☐Text (phone provider ___________________) ☐Email ☐Phone Call

EMERGENCY CONTACT

Name: ____________________ Phone Number: _____________________ Relationship to Patient: ______________

INSURANCE INFORMATION

Primary Insurance: ________________________________ ID # ____

Secondary Insurance: ______________________________ ID # ____

CASE INFORMATION

What are you being seen for: ____________________________ When did this occur: __________________________

Referring Physician: ______________________ Phone Number: ____________________________

Date of Last Appointment: _________________ Date of Next Appointment: __________________

Primary Care Physician (if different): _____________________ Phone Number: ____________________________

Was this a Motor Vehicle Accident? ☐ Yes ☐ No If yes, what state did the accident occur in? ________________

Is this a Workers Compensation Case? ☐ Yes ☐ No

How did you hear about us? ☐ Doctor ☐ Family/Friend ☐ Internet Search ☐ Insurance Company ☐ Other

Whom may we thank for your referral? ____

Signature: _________________________________ Date: __________________

move well ● move often ● be well

Patient Name: ______________________________________ **Today's Date:** __________________

A Step Ahead Physical Therapy is dedicated to providing the best possible care for you in a warm, comfortable environment. All services are provided by a licensed Physical Therapist.

By signing below I acknowledge and consent to the following, where applicable:

1. **MEDICAL CONSENT:** I authorize A Step Ahead Physical Therapy to perform physical therapy assessment and treatment which will be discussed with my therapist.
2. **TELEHEALTH AUTHORIZATION:** A Step Ahead Physical Therapy may be providing my therapy services via telehealth if needed. I understand that my appointments may be virtual taking place with an application discussed by me and my therapist. I understand that A Step Ahead Physical Therapy is not responsible for any injury or damage that my result from the use of the techniques taught or the information provided during a telehealth visit. I understand that I am participating in telehealth physical therapy at my own risk.
3. **PAYMENT FOR SERVICES:** I understand that payment is expected at the time of service for all services and I am fully responsible for all fees that are not covered by my insurance except those prohibited by the insurance carrier if we are in network. Out of network insurance will be billed at full rate and any reductions taken by my insurance company are my responsibility. Insurance will be filed for services rendered as directed by me. Co-pays or co-insurance are expected at the time of service. I will be billed for any portion that my insurance company does not cover if out of network.
4. **MEDICAL INSURANCE BENEFITS:** A Step Ahead Physical Therapy will verify my insurance coverage prior to service and filing claims. Based on this information, A Step Ahead Physical Therapy will estimate the portion of charges for which I should be responsible, taking into consideration coordination of benefits should I have coverage under multiple insurance policies. A Step Ahead Physical Therapy is not responsible for any incorrect information my carrier has relayed to them. There are *no guarantees* to the accuracy of the verification process or any payment amounts received from my insurance company. The final indicator of coverage is the Explanation of Benefits (EOB). I am responsible for any balances not covered by the policy. Disputes regarding benefits are between the patient and insurance company. I will notify A Step Ahead Physical Therapy of any changes in my insurance.
5. **MEDICARE AUTHORIZATION:** I certify that the information given in applying for payment under TITLE XVII of the Social Security Act is correct and requests payment of authorized benefits to be made on my behalf. I authorize A Step Ahead Physical Therapy to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information needed for Medicare claims, including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished.
6. **CANCELLATION POLICY:** A Step Ahead Physical Therapy asks that I give **24-hour prior notice for cancelling** or rescheduling appointments as a courtesy to the Therapists and to other patients trying to schedule appointments. Appointments cancelled with less than 24 hours that cannot be rescheduled that same day are considered a "Same Day Cancellation". After reaching three (3) "Same Day Cancellations", all of my scheduled appointments will be removed and I will be placed on the Day to Day list where I will be required to call in day to day to see if there is an appointment available that fits my availability. I will be informed of the times open (if any) for that day/for each therapist. This allows me to have more flexibility with appointments, but I will not be guaranteed the same therapist each visit. Appointments cancelled due to suspected exposure to COVID-19, awaiting test results, current illness or weather emergencies will not count against me.

Patient Name: ______________________________________ **Today's Date:** __________________

7. **SCHEDULING POLICY:** A Step Ahead Physical Therapy schedules a full hour of therapy for each patient. No other patients are scheduled with that therapist at that time. This ensures I am receiving the best care and getting the most out of my rehabilitation. I may request shorter or longer appointments if deemed appropriate by my therapist.
8. **TELEHEALTH INSURANCE COVERAGE:** I understand that my insurer may consider telehealth a non-covered service and I am responsible for payment in the case that my insurer does not pay for telehealth. I understand that many insurance providers are paying for telehealth. Please choose one of the following options:
   - ☐ **OPTION 1** I want telehealth therapy. I want my insurance to be billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB) by my insurance. I understand that if my insurance does not pay, I am responsible for payment and I can appeal to insurance by following the directions on the EOB. If my insurance does pay, I may still be responsible for my co-pays, co-insurances or deductibles.
   - ☐ **OPTION 2** I want telehealth therapy, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if insurance is not billed.
9. **TELEHEALTH PAYMENT FOR SERVICES:** I understand that payment is expected for all services provided by A Step Ahead Physical Therapy. I understand that A Step Ahead Physical Therapy will bill me in accordance to the fee schedule below for the telehealth service and I am responsible to pay for these services on receipt of the bill.

Telehealth Fee Schedule

Telehealth Session Length	Telehealth Fee
Up to 15 minutes	$40
16 – 30 minutes	$80
31 – 45 minutes	$120
46 – 60 minutes	$160

10. **SELF PAY DISCOUNT:** A discount is available to those who pay in full at the time of service and do not require A Step Ahead Physical Therapy to file claims with health insurance. If I choose for A Step Ahead Physical Therapy not to file claims or take any insurance information, I may file with my health insurance on my own. In this case A Step Ahead Physical Therapy will provide the proper receipts and documentation to be submitted.
11. **MEDICAL RECORDS RELEASE:** I authorize A Step Ahead Physical Therapy to release any medical records (including any information furnished to A Step Ahead Physical Therapy or obtained by A Step Ahead Physical Therapy in connection with my treatment) to any referring physician, insurance company, health care facility, or government agency requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer.

I authorize the release of any medical information to the following person(s):

Name: ____________________________________ Relationship ___________________________________

Name: ____________________________________ Relationship ___________________________________

12. SELF-REFERRED/DIRECT ACCESS: I understand that a physical therapist diagnosis is not a medical diagnosis by a physician or based on radiological images and that such services might not be covered by my health plan or insurer.

Self-Referred/Direct Access allows for treatment for 21 days or **8 visits** from the initiation of a physical therapy plan of intervention. Medicare and Medicare replacement plans do not allow for physical therapy treatment without a physician referral.

I understand that if I am a self referred patient I am unable to receive dry needling without my Physical Therapist consulting with my Physician.

13. STUDENT OBSERVATION: A Step Ahead Physical Therapy has several observation internships with students within our clinic. Students are required to complete a certain number of observation hours before applying to a Physical Therapy Program. In regard to this A Step Ahead Physical Therapy has made me aware of my rights as a patient. I can request not to be observed by a student and different arrangements will be made, including a private room. My comfort is of utmost priority and every step will be taken to ensure that I feel comfortable with my treatment.

This is observation only; there is no 'hands on' treatment by any intern.

Yes, I allow students to observe my treatment. _____________

No, I prefer no student observe my treatment. _____________

14. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE: I acknowledge that I have been given a copy of the Notice of Privacy Practices and am providing consent for the use of my protect health information in the manner described in the Notice of Privacy Practices.

Patient Name: ____ **Date of Birth:** ___________________

Signature: ____ **Today's Date:** ___________________

If Patient is a minor, to be signed by Parent or Guardian

Printed Name of Parent or Guardian: _______________________________________

TO BE FILLED OUT BY OFFICE

The following information applies: ☐ Self Referred/Direct Access

☐ Commercial Insurance ☐ Self Pay Discount ☐ Workers Compensation ☐ Auto Accident

A Step Ahead Physical Therapy will file with: ☐ Medicare ☐ In Network Insurance ☐ Out of Network Insurance

The above information was reviewed with the client by: ____

A Step Ahead Physical Therapy Staff Signature: _____________________________________ Date: ________________

HEALTH HISTORY

Name: _______________________________ Height: ______ Weight: ______ Age: _______ Date: ____________

Highest Level of Education: ________________________ Employment: _____________________________

Rate your health: ☐Excellent ☐Good ☐Fair ☐Poor Have you had any major life changes in the past year?☐Yes ☐No

Average Blood Pressure: _______________ Are you: ☐ Right Handed ☐ Left Handed

Do you exercise regularly? ☐ Yes ☐ No If yes, how often and what types? ________________________________

Tobacco use? ☐Never ☐Past ☐Current; If current type/how much?____

Alcohol use? ☐Never ☐Past ☐Current; If current type/how much?____

Do you have any customs/religious beliefs/wishes that might affect care? _____________________________________

Medical/Surgical History: ☐Arthritis ☐Blood Disorders ☐Broken Bone/Fracture ☐Cancer ________________

☐Circulation/Vascular ☐Depression ☐Developmental/Growth Problems ☐Diabetes ☐Eating Disorder

☐Gynecological Problems ☐Head Injury ☐Hearing Problems ☐Heart Conditions or Heart Attack ☐Hepatitis ☐Hernia

☐High Blood Pressure ☐HIV/AIDS ☐Infectious Disease ☐Irregular Menstruation ☐Joint Replacement ☐Kidney Problem

☐Lung problems ☐Memory Problems_________ ☐ Multiple Sclerosis ☐Osteoporosis ☐Parkinson's Disease

☐Prostate Disease ☐Seizures/Epilepsy ☐Stroke ☐Thyroid Problems ☐Ulcers/Stomach Problems ☐Other_______

☐History of COVID-19 ☐Lingering Side Effects from COVID-19____________________________________

Within the past year, have you had any of the following symptoms? ☐ Abdominal/Pelvic Pain

☐Bowel Problems/Constipation ☐Chest pain ☐Coordination Problems ☐Difficulty Sleeping ☐Difficulty Swallowing

☐Difficulty Walking ☐Dizziness/Fainting ☐Falls; if yes #________ ☐Fatigue ☐Headaches ☐Hearing Problems

☐Heart Palpitations ☐Joint Pain/Swelling ☐Loss of Appetite ☐Loss of Balance ☐Pain at Night

☐Shortness of Breath ☐Urinary Problems/Leakage ☐Vision Problems ☐Weakness in Arms/Legs ☐Weight Gain/Loss

Please list any relevant family history: ____

Surgeries including approximate date: ☐ N/A

____

____

____

Medications (prescription, nonprescription and supplements)
Include frequency and dosage; continue on back if necessary

☐ N/A ____

____

____

With whom do you live with? ☐Alone ☐Spouse ☐Child

☐Other Relative ☐Other ___________________________

Where do you live? ☐House ☐Apartment ☐Other________

Does your home have: ☐ Stairs, w/ railing ☐Ramps

☐Stairs, w/ no railing ☐Uneven Terrain ☐Other ___________

Do you use: ☐Cane ☐Walker ☐Manual Wheelchair

☐Motorized Wheelchair ☐Other ___________________

Allergies: Do you have a latex allergy? ☐Yes ☐No

List other allergies

____

____

For Women: Are you pregnant or think you might be pregnant? ☐Yes ☐No

Therapist Initials: _________

move well • move often • be well

CURRENT CONDITION

Name: ________________________________ Date: ________________

When did this problem begin? __________________

What happened? ____

Surgery: ☐ Yes ☐ No; If Yes, Type: _____________________________ Surgery Date: ____________________

Have you ever had this problem before? ☐Yes ☐No If yes, when? __________________________________

If yes, what did you do for the problem? ____

How long did the problem last? ________________________ Did the problem get better? ☐Yes ☐No

How are you taking care of the problem now? ____

What makes the problem worse? ____

What activities are you not able to do now due to the problem? ____

What are your goals for physical therapy? ____

Are you seeing anyone else for the problem? ____

Clinical Tests Performed for this Condition:

☐Angiogram ☐Bone Scan ☐CT Scan

☐Electrocardiogram ☐MRI ☐Nerve Conduction Test

☐Stress Test ☐Ultra Sound ☐X-Rays

Please rate the level of your pain:

At present: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

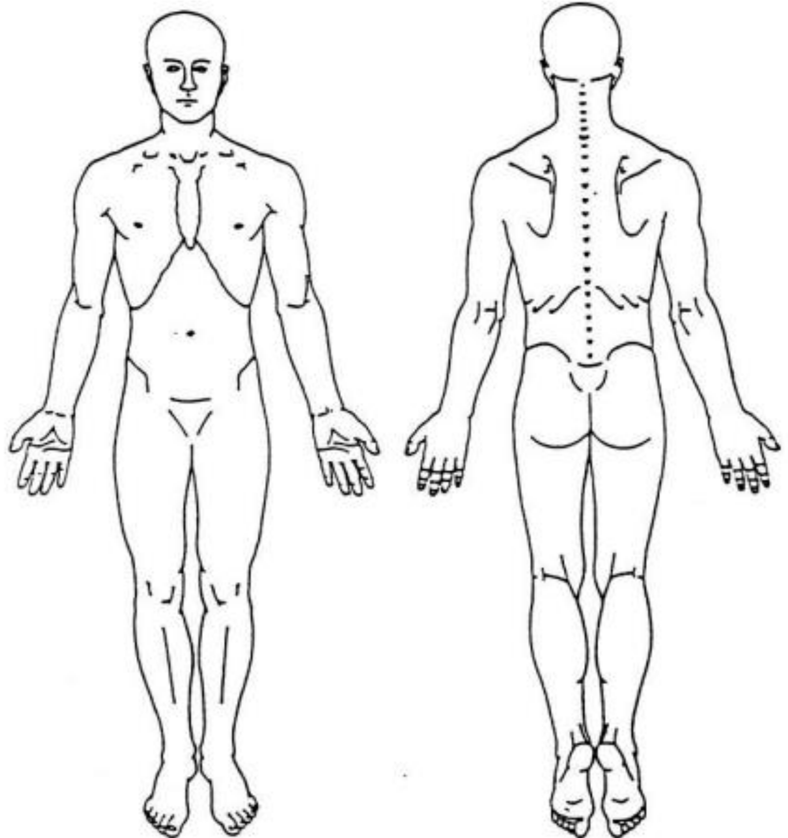
No pain Moderate Extreme

Which of these words describes your pain?
(circle all that apply)

Aching Burning Constant Cramping

Dull Numb Radiating Sharp Tingling

Please mark painful areas:



Therapist Initials: _________

move well ● move often ● be well

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NOTICE OF PRIVACY PRACTICES

Updated November 2020

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.

USES AND DISCLOSURES: Your protected health information (PHI) will be used for the purposes of treatment and health care operations. Please see examples of each below.

Treatment: Sharing of medical information between healthcare providers that are involved in your care (i.e. your physician, other therapists, etc.).

Payment: Sending of billing information to your insurance company.

Health Care Operations: Periodic quality assurance monitoring.

Other Special Uses: Use of your PHI to contact you for an appointment reminder or to inform you of other health-related services.

In addition to the above uses, your PHI may be utilized or disclosed under the following circumstances:

- With a family member or friend involved in your care if you do not object
- In an emergency situation when you may not be able to express yourself
- When required by law, by court order or subpoena
- When necessary to comply with Worker's Compensation, U.S. Military, or similar programs that provide benefits for your work-related injury or illness
- When necessary to prevent or lessen a serious threat to the health or safety of another person or the public

For all other uses not mentioned above, you will be asked for your written authorization.

PATIENT PRIVACY RIGHTS

Restrictions: You have the right to request restrictions on how your PHI is used; however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential: You have the right to request communications in a confidential manner such as providing alternate address or phone number. We are an open clinic with patients receiving treatment in close proximity to each other. Private rooms are available upon request. Not all treatments are able to be performed in a private room.

Access to Medical information: You have the right to inspect or request a copy of your medical information. A reasonable fee for copying and postage may be charged.

Amendments: If you disagree with any of your PHI, you have the right to request in writing an amendment be made. If a mutual agreement cannot be made, then the request is not required to be granted. In this case, your written statement of disagreement will become a part of your record. Also, any part of your medical record that was created by other entities or providers may not be amended by this provider.

Accounting of Disclosures: You have the right to request an accounting of the disclosures made except for those that were made with your specific authorization or for treatment, payment or health care operations.

COMPLAINTS

At any time that you feel that your privacy rights have been violated, you may register a complaint in writing to Brad Freemyer, PT @ 930 Woodstock Rd, Suite 310, Roswell, Ga 30075. In no circumstance will you be penalized or receive retaliation for any complaint. If you are not satisfied with the response to your complaint, you may complain directly to the U.S. Secretary of Health and Human Services.

OUR DUTY TO PROTECT YOUR PRIVACY

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, Our Notice of Privacy Practices and to follow the terms listed. We reserve the right to update this notice. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.