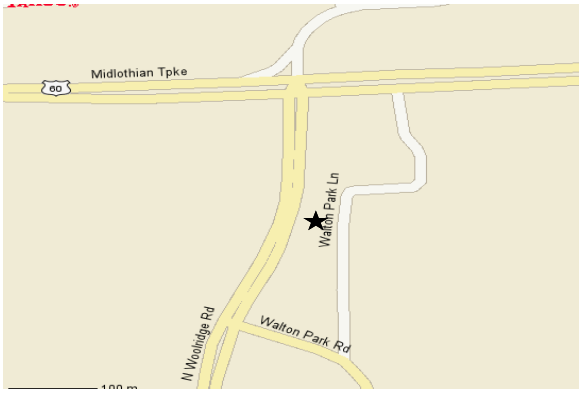
Welcome!

And thank you for choosing Advanced Physical Therapy, Inc.

Our mission is to offer you the highest quality care in a comfortable, efficient and safe manner.

Your appointment is on _____ at _____ with _____.



From Huguenot/Courthouse Rd
Take Midlothian Turnpike West (60W)
Go 1.5 Miles
Turn left onto N. Woolridge Rd.
Turn left at the first traffic light (Walton Park Rd.)
Immediate left onto Walton Park Ln.
Pass the Goddard School
APT is on the left

From Powhite Parkway (Rt. 76)
Take Midlothian Turnpike West (60W)
Go 5.2 Miles
Turn left onto N. Woolridge Rd.
Turn left onto Walton Park Road
Immediate left onto Walton Park Ln.
Pass the Goddard School
APT is on the left

From 288 (Brandermill/Woodlake)
Take Woolridge Road North
Go 2 Miles (to the 3rd traffic light)
Turn right onto Walton Park Rd.
Immediate left onto Walton Park Ln.
Pass the Goddard School
APT is on the left

From 288 (West End)
Take Woolridge Road North
Go 2 Miles (to the 3rd traffic light)
Turn right onto Walton Park Rd.
Immediate left onto Walton Park Ln.
Pass the Goddard School
APT is on the left

108 Walton Park Lane • Midlothian, VA 23114
(804)560-9575 • (804)560-9557 (facsimile)

ADVANCED PHYSICAL THERAPY, INC.

The New Science in Sports Performance and Pain Rehabilitation

PERSONAL INFORMATION

NAME: _____
First M.I. Last

ADDRESS: _____
Street City State Zip

HOME PHONE: _____ CELL PHONE: _____

E-MAIL: _____ Would you like to receive our newsletter by E-mail? yes / no

SOCIAL SECURITY NUMBER: _____ BIRTH DATE ___/___/___

MARITAL STATUS _____ < > MALE < > FEMALE

EMPLOYER: _____ WORK PHONE _____EXT. _____

PARENT OR RESPONSIBLE PARTY (if different than patient) _____

HOW DID YOU HEAR FROM ADVANCED PHYSICAL THERAPY? (Friend? family member?) _____

SPOUSE/GUARDIAN INFORMATION

HIS/HER NAME _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____ EXT _____

BIRTH DATE __/___/___ SOCIAL SECURITY NUMBER _____ HOME PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____	SECONDARY INSURANCE _____
INSURANCE ADDRESS_____	INSURANCE ADDRESS_____
_____	_____
NAME OF INSURED _____	NAME OF INSURED _____
INSURED'S DOB _____	INSURED'S DOB _____
INSURED'S ID # _____	INSURED'S ID # _____
GROUP # _____	GROUP # _____
EMPLOYER'S NAME _____	EMPLOYER'S NAME _____
RELATIONSHIP TO PATIENT _____	RELATIONSHIP TO PATIENT _____

WORKERS COMPENSATION/ ACCIDENT INFORMATION

WC CONTACT NAME _____ PHONE # _____ FAX # _____

INSURANCE COVERAGE _____ CLAIM # _____

ACCIDENT DATE ____/____/____ ACCIDENT TIME _____ DATE OF ONSET OF SYMPTOMS ___/___/___

PLEASE DESCRIBE ACCIDENT _____

IS AN ATTORNEY INVOLVED? < > YES < > NO NAME OF ATTORNEY _____

FIRM _____ ADDRESS _____

I, _____, consent to treatment by Timothy J. Wittenauer, MSPT, CFMT, his designees, assistants, and staff. Recognizing that I have a condition requiring medical care and further acknowledge that I am aware and affirm that no guarantees have been made to me concerning treatment by ADVANCED PHYSICAL THERAPY, INC., I hereby instruct the above named Insurance Company to pay by check made to and mailed directly to ADVANCED PHYSICAL THERAPY, INC.

Patient's Signature: _____ Date: _____

Primary Doctor: _____ Referring Doctor: _____

108 Walton Park Lane • Midlothian, VA 23114
(804)560-9575 • (804)560-9557 (facsimile)

ADVANCED PHYSICAL THERAPY, INC.

The New Science in Sports Performance and Pain Rehabilitation

TO OUR PATIENTS
PLEASE READ AND SIGN

Our Cancellations and No Show Policy: We take this subject seriously at the clinic, because it can make a difference between whether you succeed in our treatment or not. Your referring doctor and/or your therapist has prescribed a set frequency of treatment. There is a $50 charge for a cancellation without a 24 hour notice. This charge will not be covered my insurance or worker's compensation. You will be responsible for this fee. _____ Initial

Regarding Insurance: We accept most major insurance plans, but you are responsible for checking with your carrier to see if services at our office will be covered. We *do not* participate with any Medicaid-HMO plans. We may accept assignment of insurance benefits; however we *do* require that all co-payments be made at the time of service. The balance is your responsibility whether your insurance company pays or not. It is your responsibility to notify us of any changes in your policy information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical plans. You will be responsible for these balances. Additionally, it is your responsibility to obtain and track referrals for your visits. _____ Initial

Commitment to make Co-Payment: In order to comply with your health insurance company's rules and regulations, you must pay your contracted co-pay at the time services are rendered. For your convenience, Advanced Physical Therapy, Inc. accepts cash, checks, credit cards and money orders. If you are seen by the physical therapist and do not pay your co-pay, a $5.00 service fee may be added to your bill. _____ Initial

Patient Remainder Statements: Upon Advanced Physical Therapy, Inc.'s payment/response from your insurance company, and at each of your visits, our Front Desk Administrator will furnish you a Patient Remainder Statement. This is our primary billing format. This statement shall reflect all amounts due from you at that time, including any co-pays, co-insurance, deductibles, and all other charges. Upon receipt of the Patient Remainder Statement, you are required to make a payment. If there are any amounts in dispute, please contact our business office immediately. If there is a discrepancy or dispute in the amount paid by you insurance company, it is your responsibility to contact the insurance carrier and resolve it. _____ Initial

Minor Patients: The adult accompanying or responsible for a minor and/or the parents (or guardians of the minor) are responsible for full payment, including all cancellation and no show charges. _____ Initial

Return Check Fee: Any returned checks will result in a returned check fee of $50. Our company is charged a fee for any returned checks and that fee must be reimbursed by the patient. Future payments must be made by cash or credit card. _____ Initial

Collection Fees: In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney fees. _____ Initial

You and the HIV Virus: We are all concerned with minimizing the risk of exposure to the HIV virus. We have very careful protocols that comply with government regulations for safety (monitored by the Occupational Health and Safely Administrations). We would like you to know that you are at no time exposed to blood or bodily fluid of any other patient. We are obligated to provide a safe workplace. There may be occasion when we are accidently in contact with your blood or other bodily fluids. Virginia Law authorizes that if such an incident occurs, we may require that you have your doctor test your blood for HIV. The same law requires that you be informed of this. These are precautions are taken in the interest of safety for you and our staff. _____ Initial

Release of Information: If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim. _____ Initial

Attire for Physical Therapy: Shorts or sweatpants with elastic waistband may be ideal particularly if we are treating the lower extremities. Loose fitting clothing (a sports bra for women) is recommended for treatment of the upper extremities. You may feel free to bring your attire for physical therapy and change at our office. Just arrive early for your appointment to allow time to change. **Please wear or bring clean socks as clean socks are required to be worn in the clinic.** _____ Initial

_____ _____

Signature of Patient or Responsible Party **Date**

108 Walton Park Lane • Midlothian, VA 23114
(804)560-9575 • (804)560-9557 (facsimile)

Initial Evaluation Form

Name _____ Date _____

Referring Doctor: _____ Family Doctor: _____

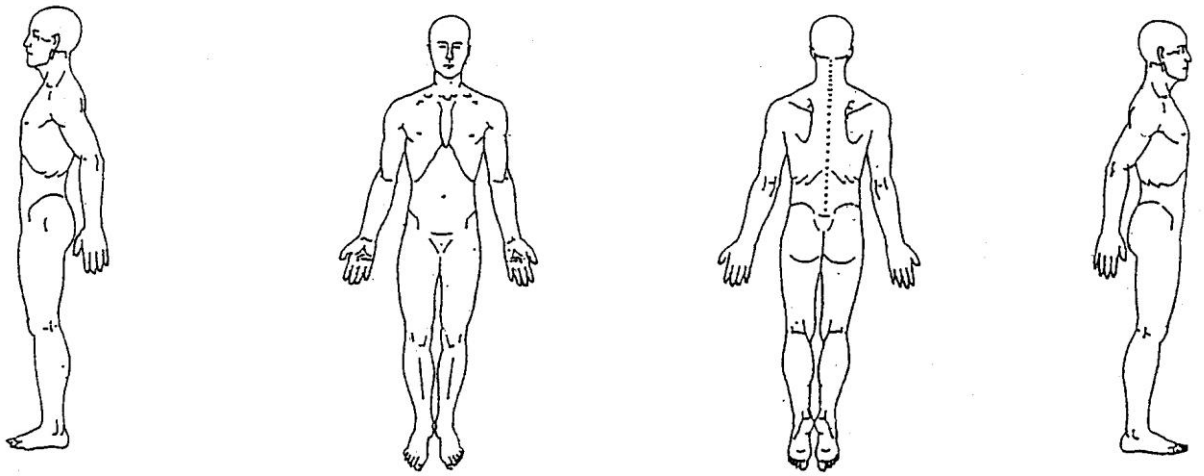
Occupation _____ Work Status (circle one): Full Time; Part Time; Retired:
Not Working due to injury (date last worked _____).

I. Chief Complaint:

List the nature of each symptom, its location, and its pain range on a 0-10 scale (0=no pain, 10=most severe pain you have experienced). Please use one or more of the following descriptors or one of your own to describe the nature of your symptoms (sharp pain, stabbing, radiating, throbbing, dull ache, numb, burning, tingling, hot, cold, weakness).

	Nature (ie, sharp pain)	Location (ie, R knee)	Pain Range (0-10)
A.			
B.			
C.			
D.			
E.			

Please shade in area or areas where you are experiencing symptoms. Please label the areas using the letters A, B, C, D, and/or E, that correspond with the above table.



108 Walton Park Lane • Midlothian, VA 23114
(804)560-9575 • (804)560-9557 (facsimile)

II. Current Symptoms:

A. Date pain / injury started (onset): _____

B. How pain / injury started: _____
_____

C. How often do you experience symptoms:
__ Constantly (76-100%)
__ Frequently (51-75%)
__ Occasionally (26-50%)
__ Intermittently (0-25%)

D. Have your symptoms: __ become worse __ become better __ remained the same

E. What makes your symptoms worse: __ sitting __standing __bending __lifting __walking _____running ____ other
Please specify: _____
_____

F. What relieves your symptoms: _____

G. Progression through day (circle):
Awakening = better / worse Midday = better / worse End of day = better / worse

H. How much does your pain interfere with your activities (please mark and list activities):
1. Daily 2. Extra-curricular
__ none (1-20%) _____
__ rarely (20-40%) _____
__ often (40-60%) _____
__ most of the time (60-80%) _____
__ always (80-100%) _____

I. Functional Score: (note: your therapist will fill in this line) _____

III. Intervention for current episode and date(s):

A. Who have you seen for these symptoms:
__ Physical Therapist, date(s): _____ __ Neurologist, date(s): _____
__ Massage Therapist, date(s): _____ __ Orthopedist, date(s): _____
__ Chiropractor, date(s): _____ __ Other Specialist, date(s): _____

B. What tests have you had for these symptoms:
__ X-ray, date(s): _____ __ EMG, date(s): _____
__ MRI, date(s): _____ __ Other, date(s): _____
__ CT Scan, date(s): _____

C. Have you had surgery for these symptoms: Yes / No. If yes, type of: _____

IV. Past history of symptoms:

A. Have you ever had these kinds of symptoms before: Yes / No. If yes, when: _____
_____

B. How often have they reoccurred: _____

C. Have your symptoms increased in their: Frequency: Yes / No; Severity: Yes / No

V. Past Medical Symptoms

A. Please check any condition listed below that applies to you:

( ) none of these apply		
( ) Asthma	( ) bronchitis	( ) emphysema
( ) Shortness of breath	( ) chest pain	( ) Coronary heart disease
( ) angina	( ) Pacemaker	( ) High blood pressure
( ) Heart attack	( ) heart surgery	( ) Stroke
( ) TIA	( ) Congestive heart disease	( ) Blood clot
( ) emboli	( ) Epilepsy	( ) seizures
( ) Infectious diseases	( ) Severe headaches	( ) frequent headaches
( ) Vision difficulties	( ) hearing difficulties	( ) dizziness
( ) fainting	( ) bowel problems	( ) bladder problems
( ) weight loss	( ) energy loss	( ) diabetes
( ) hernia	( ) any pins or metal implants	( ) currently pregnant
( ) Cancer	( ) chemotherapy / radiation	( ) Osteoporosis
( ) Long term steroid usage		

( ) Are you a current smoker? Y / N Have you ever smoked in the past? Y / N If yes to either question, how many packs? _____ for how many years? ____

Please explain any condition that you have marked above:

_____

B. Please list ALL current prescription or non-prescription medications and include **name** of medication, **dosage, frequency,** and **route of administration** (example 50mg tablet) (OR bring a printed list of medications supplied by your pharmacist or physician):

_____

_____

C. List ALL previous surgeries and dates: _____

_____

D. List previous accidents or injuries and dates: _____

_____

E. List previous physical therapy or bodywork (i.e., chiropractic, massage, acupuncture) and dates:

_____

Medicare Patients Only:

1. Have you hade 2 or more falls in the past year? Yes / No
2. Have you had a fall that resulted in an injury in the past year? Yes / No
3. Height: _____ Weight: _____

VI. Physical Therapy Goals (what would you like to get out of physical therapy?)

A.

B.

C.

D.