

PATIENT INFORMATION SHEET

PATIENT NAME _____ SEX M F DOB: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DL. # _____ SOCIAL SECURITY # _____

HOME # _____ CELL # _____

EMAIL _____

OCCUPATION _____ EMPLOYER NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK NUMBER _____ EXT _____

EMPLOYER STATUS (CIRCLE ONE)

NOT EMPLOYED FULL TIME PART TIME STUDENT [PT/FT] RETIRED

NATURE OF ACCIDENT: _____ **DATE OF INJURY:** _____

- | | |
|---|------------------------------------|
| <input type="checkbox"/> INJURED AT HOME? | IS THIS A WORK COMP INJURY? YES/NO |
| <input type="checkbox"/> INJURED AT SCHOOL? | *REFERRING PROVIDER: _____ |
| <input type="checkbox"/> DURING RECREATION? | REFERRAL SOURCE: _____ |
| <input type="checkbox"/> WORK INJURY? | ARE YOU ABLE TO WORK? YES/NO |
| <input type="checkbox"/> ACCIDENT/ OFF-ROAD | |
| <input type="checkbox"/> VEHICLE COLLISION? | |
| <input type="checkbox"/> ILLNESS? | |
| <input type="checkbox"/> OTHER? | |

MARRIED DIVORCED SINGLE MINOR WIDOWED LEGALLY-SEPARATED

SPOUSE'S NAME _____ OCCUPATION _____

EMPLOYER _____ PHONE _____

PRIMARY INSURANCE COMPANY NAME _____
NAME OF RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT _____
DOB: _____
EMPLOYER/ GROUP NAME: _____ SS#: _____

SECONDARY INSURANCE CARRIER _____
NAME OF RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT _____
DOB: _____
ADDRESS _____ RELATIONSHIP TO PATIENT _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS ON MY BEHALF. I ALSO AGREE TO BE FULLY RESPONSIBLE FOR ALL LAWFUL DEBTS INCURRED BY MYSELF FOR SERVICES RECEIVED FROM ADVANCED THERAPY CENTER, AND CONSENT TO MEDICAL TREATMENT, WHETHER COVERED BY INSURANCE OR NOT.

PATIENTS SIGNATURE _____ DATE: _____

MEDICAL HISTORY

Name: (Last) _____ (First) _____

Referring Physician: _____ Primary Physician: _____

Do you have/ or had any of the following? *(Please check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Circulatory disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer or radiation/chemotherapy |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Sensitivity to ice/ cold |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Previous surgery |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Nervous disorders | <input type="checkbox"/> Metal implants or pins |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Previous joint injuries/surgeries |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Emotional/Psychological Problems |
| <input type="checkbox"/> Do you smoke | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis/painful or swollen joints | <input type="checkbox"/> Embolism (blood clot) |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> Vision or hearing difficulties | <input type="checkbox"/> Bowel or bladder issues |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Weakness |

ALLERGIES _____
 Other Illnesses _____

Any other medical history that could assist us in your care: _____

Are you currently taking any medications? If so, please list: _____

Are you currently having Physical Therapy at another facility? _____

We know you have a choice when it comes to choosing a medical provider for your therapy needs, we feel honored that you have chosen our facility to help you in your recovery. We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policies.

As a courtesy, we call your insurance company to obtain information regarding your benefits, co-payments and deductibles. However, **you the patient are ultimately responsible for payment** should your insurance company decide not to pay for any reason. We strongly recommend you take the time to verify your coverage, eligibility and payment responsibility for occupational therapy services.

***Private Health Insurance**

If you have a **co-payment**, it is **due** at the time of treatment. We will bill your insurance company on a weekly basis for services rendered the week prior. For insurance companies that we do not contract with services rendered will be your responsibility at the usual and customary rates for this area. Should you have any questions regarding your insurance coverage, we will gladly assist you; however, it is your responsibility to know the benefits and limitations of your particular insurance policy.

***Medicare**

We will bill Medicare for you and will also bill your secondary insurance carrier, if applicable. Medicare pays approximately 80% of the allowed amount, and your secondary pays the remaining 20%. **Please note:** we will bill you **directly** for supplies not covered by Medicare. Please sign the forms attached allowing us to bill your secondary insurance company and to have them send payment directly to our office. **Additionally:** if your secondary insurance company makes payment to you (personally), and not to our office, due to contractual obligations, you are **ultimately responsible** for the **difference** between the amount **paid** by Medicare and the total allowable amount billed, **per date** of service.

***Workers Compensation**

You will be immediately responsible for therapy costs if your workers compensation carrier denies the claim for any reason {i.e.: litigation or failure to file a claim}. Your case manager will be notified of any missed appointments, and this may jeopardize your claim. Please contact the office, should you need to reschedule your appointment.

*** We do not accept liens**

We reserve the right to discontinue treatment if you fail to comply with the policies stated above.

Twenty-four hours notification is **required** when canceling or rescheduling an appointment. There will be a **fee** of fifty dollars (\$50) when notification has not been provided within 24 hours of your appointment time and for all no-show appointments.

Signature:

Dated:

Patient or Legal Guardian

- I hereby give authorization for payment of medical insurance benefits to be made directly to **Advanced Therapy Center** as indicated at the top of this form and any assisting therapist for services rendered.
- Co-payments are due at the time of service. We accept credit cards, checks and cash. There is a fee for checks that do not clear
- I understand that I am financially responsible for all charges whether or not they are covered by my insurance.
- I understand that all charges are due and payable when services are rendered, unless other payment arrangements are made with the front office/owner. I agree to pay finance charges, at the rate of one and one-half percent (1 1/2%) per month, on any amount that is 30 days past due.
- In the event of default, I agree to pay all costs of collection and reasonable attorney's fee.
- I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits.
- I further agree that a photocopy of this agreement shall be as valid as the original.

Thank you for your cooperation.

I have read, understand, and agree to the above stated financial policies. I **consent** to **therapeutic treatment** and services rendered here which include those modalities and/or procedures prescribed by my physician. I hereby state that the information I have provided is true and correct to the best of my knowledge.

Signature:

Dated:

Patient or Legal Guardian

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accounting Act of 1996 (HIPAA).

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

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, for other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day to day activities and management of **Advanced Therapy Center**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include the following:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of the notice

Advanced Therapy Center Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting

Privacy Officer
Advanced Therapy Center
3475 Torrance Blvd STE B2,
Torrance, CA 90503.

Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ *Birthdate* _____

Signature _____

Date _____

Complaints or Comments

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Advanced Therapy Center
3475 Torrance, Blvd STE B2
Torrance, CA 90503

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

BENEFICIARY REPAIR AND REPLACEMENT POLICIES

Part of my treatment at Advanced Therapy Center may include being fitted with a non-custom orthosis, and/or the fabrication of a custom orthosis for my hand/upper extremity. I understand that the orthosis is an extremely vital component of my rehabilitative process as dictated by my referring physician.

Minor repairs and adjustments within the initial 6 weeks will be provided without charge. **Repairs due to negligence are not covered** (i.e. loss of orthosis, melt damage due to heat exposure, or broken orthosis due to excessive loading).

I understand that a replacement orthosis is not always covered by my insurance. Because of this, Advanced Therapy Center must charge for a replacement orthosis prior to being re-issued or fabricated.

Name/Signature

Date

APPOINTMENT SCHEDULING

We understand how difficult it is to juggle work, school, childcare, appt's, etc. We do our best to accommodate everyone when scheduling appointments. However we do get the occasional call from a patient that needs to cancel an appointment or reschedule. For this reason we may call you to switch your appointment time or day. Please help us accommodate your wishes in the event of a cancellation or schedule change.

Do you prefer mornings or afternoons? _____

What is your preferred window of time? _____

Are there any times that will not work? Yes Please list: _____
No

What are your day preferences? (Circle) Mon. Tues. Wed. Thurs. Fri.

Are you flexible to be called to change an appointment? Yes No

If yes, on a scale of 0 to 10 how flexible are you? 0 being not flexible and 10 being very flexible.

Any other comments?

Thank you,

Advanced Therapy Center