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advancedtherapy
INNOVATIONS

5236 Vogel Rd. Ste A Evansville, IN 47715
Phone: 812-437-7868 Fax: 812-437-7228
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PATIENT INFORMATION AND AUTHORIZATION FORM

Name: ____ **DOB**: _____/_______/_________
Last First MI

Social Security No:__________-________-__________ **Gender**: (Circle One) Male Female

Mailing Address:____
Street name City ST Zip

Cell Ph#:(_______)________-_______________ **Home Ph#**:(________)________-_____________

May we leave a detailed message on voicemail: YES / NO (Which phone do you prefer? Cell Home)

E-Mail:____ **Would you like appointment reminders**? Call Text Email

Marital Status: (Circle One) Married Separated Divorced Single Widowed Partnered

Current Work Status: (Circle one) FT/PT/Retired/Unemp/Disabled/Restricted Work/Student/ Not Working Due to Injury

Is this condition due to: (Circle One) Auto Accident Work Comp Injury Slip and fall **Date of Injury/Accident**__________________

Emergency Contact: Name:______________________________ Ph#:(______)______-_________ Relationship to Patient: __________

Responsible Party's Information if different than patient:

Name:____ DOB:______/______/__________ SSN:_________-______-____________

Relation:______________________ Address:____

Phone:(________)_________-_____________

How did you hear about us: Doctor Website Yellowbook Facebook Friend:_______________________ Other:_________________

If an Attorney or a Case Manager is working with you on an injury case, please provide their Name, and Ph #:

Name:____ Ph#(________)________-______________

If this is due to an Accident that is car/work related please provide us with the following:

Claim No.:________________________________ Contact/Adjuster:____

Phone#:(_______)_______-___________ Claims Address:____

Have you received physical/occupational therapy this calendar year? Yes / No

If yes, please state where and when:____

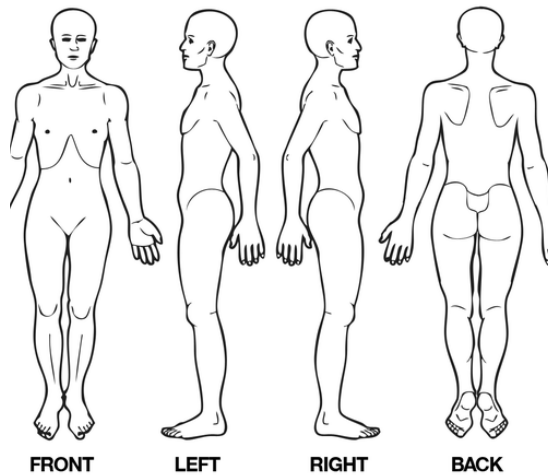
I hereby authorize Advanced Therapy Innovations to treat me as ordered by my physician.

Signature:____ **Date**:________________________

CHECK THE CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

Condition	Past	Now	Condition	Past	Now	Condition	Past	Now	Condition	Past	Now	Condition	Past	Now
Asthma			Pregnancy			Diabetes			Herniated Disc			High Blood Pressure		
Stroke			Surgery			Osteoarthritis			Heart Disease			Cigarette smoker		
Angina			Tumor			Neuropathies			COPD			Parkinson's Disease		
Cancer			PVD			Broken Bones			Multiple Sclerosis			Sciatica		
Lupus			HIV/Aid			Pacemaker			Back/Neck Injuries			Joint Replacement		
Dizziness			Fainting			Hernia			Rheumatoid Arthritis			Seizures		

Current Pain Location: (Mark where your pain is currently located on the diagram below)



HIPAA Release

Due to HIPAA regulations we request that you assign individuals who are allowed to call for information such as dates of service, billing information, and setting/confirmation of appointment times. We will not discuss any of your medical history with these individuals unless you specifically sign a release allowing us to do so. Please list these individuals below:

1. Name:______________________________ Relationship:______________________________

   Address: ____

   Phone Number: (_______)_______-________

2. Name:______________________________ Relationship:______________________________

   Address: ____

   Phone Number: (_______)_______-________

Acknowledgement of Notice of Privacy Practices (HIPAA)

I, ______________________________, have been offered a copy of the Notice of Privacy Practices from Advanced Therapy Innovations.
(Signature)

PATIENT AUTHORIZATION TO BILL INSURANCE

NOTIFICATION OF PATIENT RESPONSIBILITY FOR CO-PAY/COINSURANCE AND DEDUCTIBLES

Your insurance company **REQUIRES** Advanced Therapy Innovations to collect your co-pay amount from you **AT TIME OF SERVICE**. If we do not collect these amounts we could be in violation of our contract with your insurance company and risk being denied re-imbursement for your treatment. Furthermore, we have an obligation to collect any coinsurance % or unmet deductible amounts from you that are determined to be your responsibility.
You will receive statements during and after your treatment for any amounts your insurance company indicates will be your financial responsibility. These statements also include the amount billed to your insurance company and the payments received from both you and your insurance company.

Advanced Therapy has verified outpatient Physical/Occupational Therapy benefits based on the information furnished to us by you. Your insurance has the disclaimer that this is a verification of benefits and **NOT** a guarantee of payment. Based on the information your insurance provided to us the **ESTIMATED** amount you are responsible for is:

Co-pay - $__________ Co-Insurance - __________% Deductible Amt - $___________ Deductible Met: Yes No

Maximum Visit - __________ Out of Pocket Max - $____________ Pre-Authorization Required - Yes No

Self Pay Patient - ____________

I understand and am fully aware I will be liable for any and all outstanding bills.

Additionally, I hereby authorize and assign insurance benefits to Advanced Therapy Innovations and the release of any and all medical records as requested by any insurance company so that my bills can be processed and paid. I understand that I am responsible for notifying Advanced Therapy Innovations of any changes regarding my medical coverage during ongoing treatment. The changes in medical coverage may include an auto accident, a work-related injury, termination of insurance, a change in insurance company and/or policies.

I have read and clearly understand the Financial Policy of **Advanced Therapy Innovations**. I agree to assign insurance benefits to **Advanced Therapy Innovations** whenever necessary.

I hereby authorize **Advanced Therapy Innovations** and any of its agents to contact me by telephone at any of the numbers provided including any wireless number for me and/or my spouse, which could result in charges to me/us. I acknowledge that I/spouse may be contacted by text message or email address as provided. Furthermore, I also authorize methods of contact that may include using pre-recorded and/or artificial voice messages and/or automatic dialing services as needed.

Signature: ____ **Date:** ______________________
Patient Signature (if under 18 parent/guardian)

We require 24 hour notice to cancel any appointment to avoid the $50.00 cancellation fee that is not payable by your insurance company.

UNATTENDED VISITS POLICY
To get full benefit from therapy, you should attend as your doctor or therapist prescribed. Therefore, if you cancel an appointment, you need to reschedule that appointment for therapy to occur the same week. If you have any problems between treatments, please do not hesitate to call our office. If your therapist is not available, we will connect you with another therapist or doctor or have your therapist/doctor return your call. Please see attached financial policy for more information.

FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill our patients. The following is a summary of our payment policy:

ALL PAYMENT IS EXPECTED AT TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-pays for all participating insurance companies**.** **Advanced Therapy Innovations** accepts cash, checks and credit cards. There is a $30.00 service charge for all returned checks.
Patients with an outstanding balance will not be rescheduled until the account is satisfied or a payment arrangement has been made.

PAST DUE/UNPAID BALANCES

If an account is not paid, we reserve the right to place the account with an outside collection agency. Any unpaid balance may result in being discharged as a patient from our practice.

INSURANCE

We will bill all participating insurance companies as a courtesy to our patients. You (the patient) are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days from the date of service, you will be expected to pay the balance in full. You are responsible for **ALL UNPAID CHARGES.**

REFUNDS

Patient overpayments will be refunded upon completion of treatment and pending charges.

ADVANCED THERAPY INNOVATIONS LLC
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEATLH INFORMATION
Effective Date 01/23/2014

This privacy notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This privacy notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information: is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
We are required to abide by the terms of this Notice of Privacy practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon request, we will provide you with any revised Notice of Privacy Practices; to obtain a copy; you may call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Advanced Therapy Innovations LLC may use your protected health information for purposes of providing treatments, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.
These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.
For treatment: Protected health information will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we might use your medical information to write a prescription of you, or we might disclose your medical information to a pharmacy when we order a prescription for you.
For payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
For health care operations: We use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund-raising activities, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician.
In addition, we may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or account information, or as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may, at times, leave this information or information about your treatment on your telephone answering machine or with the person who answers your phone.
Further, we may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy official to request that these fund-raising materials not be sent to you.

OTHER PERMITTED AND REQURED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use and disclose your protected health information in the following instances if we inform you in advance of such use or disclosure and if you have the opportunity to agree, object or restrict the use or disclosure.
Others involved in your Healthcare. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. In addition, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. If you are unable to agree or object to such a disclosure, we may disclose limited information, as necessary, if we determine that it is in your best interest based on our professional judgment.
Disaster Relief Purposes. We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:
Required by Law. We may use or disclose your protected health information to the extent the use or disclosure is required by low. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
Public Health Activities. We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. Te disclosure will be made for the purpose of controlling disease, injury or disability.
Communicable Diseases. We may disclose your protected health information if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.
Abuse or Neglect. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state law.

BREACH NOTIFICATION

A breach is defined as an event in which the dissemination, acquisition or release of patient information that compromises its security or privacy. We are required to notify you of any event in which a breach has happened, unless the information was encrypted and has no chance of being released. This will be done utilizing an attorney to write a legalized letter.

ELECTRONIC COMMUNICATION

We may not disclose any information via email unless done so on a secure system.