



PATIENT INFORMATION AND AUTHORIZATION FORM

Today's Date ____/____/____ Social Security No. _____ - _____ - _____

First Name _____ Last Name _____

Birth Date ____/____/____ Age _____ Sex: (Circle One) Male Female

Address _____ City _____

State _____ Zip _____ Home Ph# _____ - _____

Work Ph# _____ - _____ Cell Ph# _____ - _____ E-Mail _____ @ _____

May we leave a detailed message on answer machine: YES / NO (please circle preferred #)

Marital Status: (Circle One) Married Single Divorced Spouse's Name _____

If spouse is policy holder spouse's SSN# _____ - _____ - _____ Date of Birth ____/____/____

Primary Physician _____ Ph# _____

(May we contact him/her?) Y N

Referring Physician _____ Ph# _____

Employer _____

Occupation: _____

Current Work Status: (Circle one) Full Time / Part Time / Retired / Unemployed / Disability / Restricted Work

Student / Homemaker / Not Working Due to Injury

Is this condition due to: ____ Auto Accident ____ Workers Comp Injury ____ Slip and fall

If an attorney is working with you, please provide their name, and Ph #

Name: _____ Ph# _____ - _____

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

If yes, please state where and when.

Please state where your problems or injuries are, and give a brief description of your current complaints.

1. _____
2. _____
3. _____

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

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
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/Aids			Pacemaker			Back/Neck Injuries			Joint Replacement		
Dizziness			Fainting			Hernia			Rheumatoid Arthritis			Seizures		

Please check any of the following pain characteristics that you are feeling:

- Sharp Dull Throbbing Numbness Burning Pins/Needles
 Constant Usually present Sometimes present Occurs once in a while

Please circle the number that represents the intensity of your pain during any movements:

- (No Pain) (Minimal Pain) (Moderate Pain) (Unbearable Pain)
 1 2 3 4 5 6 7 8 9 10

Please circle the number that represents the intensity of your pain at rest:

- (No pain) (Minimal Pain) (Moderate Pain) (Unbearable Pain)
 1 2 3 4 5 6 7 8 9 10

Please check all the problems that you currently have that are related to today's condition:

- Inability to work Difficulty walking Extreme Fatigue Loss of Balance
 Headaches Unable to sleep Unable to walk stair Difficulty with daily task

Patient Signature / FDA

Date

_____ / / _____



PATIENT AUTHORIZATION FORM

Patient Name (print): _____ **Pt. Acct #** _____

Emergency Contact Name: _____ **Ph#: ()** _____ - _____

Relationship to Patient: _____

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

INSURANCE AUTHORIZATION SECTION

Advanced Therapy Innovations strongly believes that patients should not pay for any services their insurance companies are obligated to cover. As a courtesy to our patients, we will bill your insurance company in an attempt to recover any payments due fully for the services provided. Any uncollected fees are billed to the patient only after all options to get paid for services have been exhausted by our Accounting Department.

I understand that I am fully 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 of insurance company and/or policies. **If I do NOT comply with this policy, I understand and am fully aware I will be liable for any and all outstanding bills.**

I further understand that I am responsible for paying the balance of charges in the event my insurance does not fully cover for all services provided, including deductible, co-pay, co-insurance or percentage authorized or limited by law.

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.

Signature: _____ **Date:** _____

(Parent Signature if under 18)

Acknowledgement of Notice of Privacy Practices

I, _____, have been offered a copy of the Notice of Privacy Practices

(Print Your Name)

from Advanced Therapy Innovations.

Signature: _____ **Date:** _____

In lieu of patient signature, I, _____, a staff member of Advanced Therapy Innovations, state that _____ has been offered our current Notice of Privacy Practices.