ADVANCED THERAPY SERVICES
An Empower Company

PATIENT NAME: ______________________________________ DATE:_______________

CONSENT FORMS

Consent for Release and Use of Confidential Information, Authorization for Payment and Insurance Information, Authorization for Release of Information, Authorization to Treat, Financial Policy, Credit Card Authorization

HIPAA Notice of Privacy Practices

In compliance with HIPAA - The Health Insurance Portability and Accountability Act of 1996: If you are a patient of Advanced Therapy Services, this notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

I voluntarily give my consent to care and treatment as recommended by the therapist(s) as is necessary in his/her clinical judgment. I hereby give my consent to Advanced Therapy Services to use or disclose Protected Healthcare Information (PHI) for the purpose of carrying out treatment, payment, or health care operations (TPO), all information contained in the patient records. This may include sharing/exchanging information with insurance carriers, and physicians or other health care professionals who are involved in my care. I authorize Advanced Therapy Services to use my information in any way that is outside of the allowable reasons under the HIPAA regulations if deemed appropriate by the therapist(s), for which an accounting of disclosures will be kept.

I give consent ☐
I decline consent ☐

I hereby authorize any prior or present treating physician, therapist, hospital, or other health/educational institute, to release all medical, health and/or educational information by any means of communication to Advanced Therapy Services.

I give consent ☐
I decline consent ☐

I consent to open communications with my therapy team which may include use of phone calls, voicemail messages, text messages, and/or email messages on all phone numbers provided by the patient/patient representative.

I give consent ☐
I decline consent ☐

Permission to release your protected health care information to patient selected representative:

Name:____ Relationship:___________________

Phone:_________________________ Consent to text/leave VM ☐

Authorization for Payment and Insurance Information

I prefer the billing for my visits to be pursued via:

Medicare Part B ☐

My Blue Cross Blue Shield PPO policy ☐

I will bill by own insurance independently as out-of-network (if not BCBS/Blue Choice) ☐

I plan to pay out-of-pocket for services as a "self-pay" patient ☐

Fees for Service

PT/OT/ST Evaluations: $150.00/visit
PT/OT/ST Routine Visits/Discharge Visits: $120.00/visit
PTA/COTA Routine Visits: $100.00/visit

I understand that any co-pays, co-insurances, unmet deductibles, or private-pay amounts are due at the time that the services are rendered. We will verify your outpatient therapy benefits prior to services being rendered and will ensure full transparency on our network status with your insurance and provide you with good faith estimate on what you should expect to pay out of pocket or as coinsurance, based on the information provided to us by your insurance company. I understand that if my insurance is accepted by Advanced Therapy Services, it is ultimately the patient's responsibility to determine insurance coverage for the services being rendered. Advanced Therapy Services will gather information regarding insurance coverage and will submit claims to select insurance companies; however, I understand this is not a guarantee of coverage. I understand that I may contact my insurance carrier directly to confirm eligibility and benefits for scheduled services. If there are **any** changes to your health benefits while receiving therapy services from Advanced Therapy Services, it is the patient's responsibility to notify your Advanced Therapy Services to avoid incurring out-of-pocket costs.
I understand that I need to bring my insurance card and photo ID to each visit. I understand that it is my responsibility to obtain and provide Advanced Therapy Services with a prescription from my doctor for the scheduled evaluations and therapy, prior to starting services. I understand that in the event balances owed to Advanced Therapy Services reach or exceed $300.00, I may be asked to discontinue services until a payment can be made. Scheduled times will not be reserved in this case. I understand that, under certain circumstances, I may be eligible for a payment plan if deemed appropriate by Advanced Therapy Services. If so, I understand that any payment plan must be paid in full within a 3-6 month time period. In the event of non-payment of a bill, I understand that this practice shall be entitled to the right of recovery for all collection expenses, including court costs and reasonable attorney fees incurred for the purpose of obtaining payment of the amount due. If my account is transferred to a collection agency, I may be dismissed as a patient.

I give consent ☐
I decline consent ☐

I hereby authorize Advanced Therapy Services permission to process my credit card, for which I am providing the information.

I give consent ☐
I decline consent ☐

I understand that payments and/or current insurance information is required at time of service. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to Advanced Therapy Services. This practice does not accept responsibility for collecting unpaid or denied insurance claims or for negotiating a settlement on disputed claims. I understand that I am responsible for charges not covered by my insurance.

I give consent ☐
I decline consent ☐

ADMISSION CRITERIA

Advanced Therapy Services provides outpatient therapy services such as physical therapy, occupational therapy, and speech therapy. Your admission to the clinic is based soley on your physician's determination that you will benefit from outpatient therapy services. Your physician and our qualified health care professionals will work to create an individualized care plan that is designed in a way that will result in the best possible outcomes towards meeting your health care goals. Your therapist will evaluate each individual for appropriateness of admission without regard to race, age, gender identity or expression, color, creed, sex, national origin, ancestry, religion, handicap, disability, marital status, or sexual preference. As a patient you have the right to participate in, be informed about, and consent or refuse care in advance of and during the treatment with respect to completion of all evaluations.

RELEASE OF LIABILITY

There are inherent risks in therapeutic services including but not limited to physical/occupational therapy, speech therapy, and swallowing therapy. I expressly assume all risks to the participant, (or others with the participant during these activities), whether such risks are known or unknown to me at this time. I further release Advanced Therapy Services' workers or clinicians from any claim that I may have against them as a result of injury or illness incurred during the course of participation in these activities. Additionally, I do hereby give permission for agents of Advanced Therapy Services to seek and secure any needed medical attention or treatment for any participants (or others with the participant), if in the agent's opinion such need arises at the sole cost of the Parent/Guardian.

I give consent ☐
I decline consent ☐

PHOTO CONSENT

I grant permission and consent to Advanced Therapy Services to use photograph(s) of myself to advance plan of care and ensure best treatment outcomes. Photographs will be stored in a HIPAA compliant/ secure location and only authorized staff and/or primary care physician will have access to them. Photographs will be kept as long as they are relevant and after that time destroyed or archived.

I give consent ☐
I decline consent ☐

I grant permission and consent to Advanced Therapy Services to take pictures or videotape patients during home health therapy activities. The images may be used for Empower Home Health displays, brochures, social media account, newsletters, and all other publicity.

I give consent ☐
I decline consent ☐

ACKNOWLEDGEMENT AND SIGNED INFORMED CONSENT

Consent for Release and Use of Confidential Information, Authorization for Payment and Insurance Information, Authorization for Release of Information, Authorization to Treat, Financial Policy, Credit Card Authorization

I, ______________________________________ acknowledge that I have thoroughly read this consent, authorization and release of information and understand the information contained within.

Patient or Legal Representative Name: ____

Signature____ Date______________

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NEW PATIENT INTAKE FORM

PATIENT INTAKE FORM PLEASE FILL OUT COMPLETELY AND CLEARLY

Personal Information:

Date:__________ Patient's Legal Name:____

Nickname:_______________________________________ ☐ Male ☐ Female

DOB: _____________

Address:____ Email: ___________________________________

Main Phone:____________________________________ Cell: ____________________________________

Insurance Information:

Primary Insurance: _______________________________ Secondary Insurance:______________________

Primary Insured Name: ___________________________ Relationship to patient:___________________

Primary Insured DOB: _____________

Primary Insured Mailing Address *(if different from the above)*:_______________________________________

Service Information:

Have you had any of the following services in the past year? ☐ PT ☐ OT ☐ Speech

☐ Chiropractic ☐ Cardiac/Pulmonary **OR** ☐ No

If yes, when/where were the services provided?____

Was it at our clinic ☐ Yes ☐ No

Was it for the same injury? ☐ Yes ☐ No

Referring Physician:______________________________________ Phone:___________________________

Emergency Contact(s)

Primary Contact:

Name:____ Relationship:____________________

Phone:___________________________

Secondary Contact:

Name:____ Relationship:____________________

Phone:___________________________

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MEDICAL HISTORY FORM

Reason for Referral: ______________________________

Please describe your current concern's (please provide as many details as possible)

____
____
____
____
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____
____
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____
____
____

Primary Care Physician:____ Last Visit Date: ____/____/____

CURRENT MEDICATIONS (Rx or over the counter, list name of medications including eye drops, vitamins & birth control pills)

____
____
____
____
____
____

ALLERGIES TO MEDICATIONS? ☐ Yes ☐ No
If yes, which: ____

List all *major* illnesses (glaucoma, diabetes, high cholesterol, Cancer, high blood pressure, etc.) or injuries (concussion, etc.):

____
____
____
____

List any surgeries you have had (cataract, appendectomy, etc.)____________________________________

____
____
____

REVIEW OF SYSTEMS: Do you currently HAVE OR HAVE HAD any problems in the following areas? If YES, please provide details:

	YES	NO	DETAILS *(date of diagnosis and treatment)*
Glaucoma			
Macular Degeneration			
Cataract Retinal Detachment/Disease			
Diabetes			
High Blood Pressure			
Blindness			
Cancer			
Cardiovascular Disease (high blood pressure, racing pulse, etc)			
Lupus			
Thyroid Disease			
Autoimmune Disease			
Stroke			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
NEUROLOGICAL (numbness, TBI, headache, seizures, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, high cholesterol, anemia, sickle cell, blood transfusions, etc.)			
ORTHO (knee, hip, shoulder replacements)			
Swallowing Disorders			
Autism Spectrum Disorder			
OTHER NOTE(S) LISTED ABOVE:			
OTHER NOTE(S) LISTED ABOVE:			

Acknowledgement:

Please sign below to acknowledge that the above information is accurate, that you have received the HIPAA Notice of Privacy Practices handout, Liability Handout, Policy Handout and to Authorization to Treat with Advanced Therapy Services for physical, speech, or occupational therapy.

Signature of Patient:____ Date:_______________

If unable to complete this form, signature of authorization from Power of Attorney (POA):

Name: ____ Relation to Patient:_________________

Signature of POA:____ Date:_______________

Cancellation Policy

It is important to your progress that scheduled appointments are attended. If you cannot make your appointment, please contact your therapist or the clinic as soon as possible. Cancellations within twenty-four (24) hours of your appointment should be avoided whenever possible.

Advanced Therapy Services' schedules patients in order to maximize opportunities for patients to be treated by our therapy team, therefore we reserve the right to charge a cancellation fee of $30.00 for cancellations or no-shows within twenty-four (24) hours. Advanced Therapy Services reserves the right to charge a cancellation fee if the patient's tardiness exceeds beyond fifteen (15) minutes.

Exceptions apply to this policy at the sole discretion of Advanced Therapy Services, for irregular situations as well as in the case of a national disaster or emergency, hospitalization, or other inpatient stay. In the case of an emergency hospitalization or other inpatient stay, Advanced Therapy Services reserves the right to open up your scheduled appointment time to other patients on the waitlist.

Advanced Therapy Services does not offer physician or diagnostic services therefore if you are experiencing a medical emergency please call your physician, go to the nearest immediate care or ER, or call 911. Cancellations for emergency services are not subject to this policy.

To inform Advanced Therapy Services of a cancellation please call 847-766-0011

Signature of Patient: ____ Date:_______________

If unable to complete this form, signature of authorization from Power of Attorney (POA):

Name: ____ Relation to Patient: ____________________

Signature of POA: ____ Date:_______________