Advanced Therapy Center
3475 Torrance Blvd, Suite B-2, Torrance CA, 90503 tel. 310-316-7748 fax 310-316-7648

PATIENT INFORMATION SHEET

PATIENT NAME _____ **SEX** ___**M**___**F** **DOB:** _____

HOME ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

DL. # _____ **SOCIAL SECURITY #** _____

CELL # _____**HOME #** _____**WORK #** _____

CAN WE TEXT: ____**YES** ____**NO** **BEST NUMBER TO REACH YOU: please circle HOME/CELL/WORK**

EMAIL: _____

OCCUPATION _____ **EMPLOYER NAME** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

EMPLOYER STATUS (CIRCLE ONE)

NOT EMPLOYED **FULL TIME** **PART TIME** **STUDENT {PT/FT}** **RETIRED**

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

- **INJURED AT HOME?**
- **INJURED AT SCHOOL?**
- **DURING RECREATION?**
- **WORK INJURY?**
- **ACCIDENT/OFF-ROAD?**
- **VEHICLE COLLISION?**
- **ILLNESS?**
- **OTHER?**

IS THIS A WORK COMP INJURY? YES/NO
***REFERRING PROVIDER:** _____
REFERRAL SOURCE: _____
ARE YOU ABLE TO WORK? YES/NO

MARRIED **DIVORCED** **SINGLE** **MINOR** **WIDOWED** **LEGALLY-SEPARATED**

SPOUSE'S NAME _____ **OCCUPATION** _____
EMPLOYER _____**PHONE #** _____

PRIMARY INSURANCE COMPANY NAME_____
NAME OF RESPONSIBLE PARTY IF DIFF. THAN PATIENT _____
DOB _____ EMPLOYER/GROUP NAME_____ SSN _____

SECONDARY INSURANCE COMPANY NAME_____
NAME OF RESPONSIBLE PARTY IF DIFF. THAN PATIENT _____
DOB_____ RELATIONSHIP TO PATIENT_____ ADD_____

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.

PATIENT SIGNATURE _____**DATE** _____

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MEDICAL HISTORY

_____ _____
PATIENT NAME DOB

_____ _____ _____
SIGNATURE DATE

_____ _____
REFERRING PHYSICIAN PRIMARY PHYSICIAN

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

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

Height _____ Weight_____ Resting Blood Pressure _____

ALLERGIES_____

Other Illnesses_____

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

_____

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

_____

Is this injury due to a fall? (Y/N) Have you fallen 2 or more times in the last year (Y/N)

Have you fallen in the past year and been injured (Y/N)

Do you smoke or use any type of tobacco? (Y/N)

Are you currently having Physical Therapy at another facility? _____

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DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD

In order to meet Medicare quality measure reporting requirements under the Physician Quality Reporting System (PQRS) we are asking you to document your current medications (to the best of your ability.)

The medication list must include ALL prescriptions, including over-the-counter/herbals/and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration.

PATIENT NAME: _____ **DOB:** _____

Date	Medication Name	Dosage	Frequency	Route of Administration	Initial

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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. If you miss an appointment, you will: 1) Be charged $55; 2) Lose the authorized visit; 3) We will notify your Adjuster. Once you have paid, you will be scheduled again. If you miss a second appointment your care will be removed from our facility. Please contact the office within 24 hrs. 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-five dollars ($55) when notification has not been provided within 24 hours of your appointment time and for all no-show appointments.

_____ _____
PATIENT NAME **DOB**

_____ _____
SIGNATURE **DATE**

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- 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 **$25 fee** for any returned checks that do not clear the bank.
- 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 you 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.

_____ _____
PATIENT NAME **DOB**

_____ _____
SIGNATURE **DATE**

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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 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.

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PRIVACY PRACTICES ACKNOWLEDGEMENT

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

_____ _____
PATIENT NAME **DOB**

_____ _____
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.

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MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Therapy Center for any services furnished to me by the listed Physician/ Supplier. I authorize any holder of medical information about me, to release to Medicare and its agents any information needed to determine these benefits; or the benefits payable to related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

PATIENT NAME: _____ **DOB:** _____

SIGNATURE: _____ **DATE:** _____

Patients Medicare Number:

Providers Name: Advanced Therapy Center
Mojca Herman, MA, OTR/L, CHT
Address/City/Zip 3475 Torrance Blvd. #B-2
Torrance, Ca. 90503

*Have You Received Any Home Health Care In The Past 2 to 3 Years? Yes/ No

*Have You Been In A Skilled Nursing Facility In The Past 2 to 3 Years? Yes/ No
*IF SO PLEASE PROVIDE A DISCHARGE DATE: _____

*Have You Received Any Occupational Therapy This Year? _____

* If So How Many Visits Were Completed? _____

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MEDI-GAP "SIGNATURE FORM"

I REQUEST THAT MEDIGAP BENEFITS BE MADE PAYABLE EITHER TO ME, OR ON MY BEHALF TO **ADVANCED THERAPY CENTER** {MOJCA HERMAN, MA, OTR/L, CHT} FOR ANY SERVICE (S) FURNISHED TO ME BY THAT THERAPIST. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE REALESED TO **ADVANCED THERAPY CENTER** AND ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

_____ _____
PATIENT NAME **DOB**

_____ _____
SIGNATURE **DATE**

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CMS MEDICARE DMEPOS SUPPLIER STANDARDS

ACKNOWLEDGEMENT FORM

I am aware that **Advanced Therapy Center** follows the CMS MEDICARE DMEPOS SUPPLIER STANDARDS. I have been provided an opportunity to review or receive the standards.

_____ _____
PATIENT NAME **DOB**

_____ _____
SIGNATURE **DATE**

26 SUPPLIER STANDARDS

Resource: Medicare Enrollment Application, DMEPOS, Form CMS-855S,
http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf [PDF]

Note: This list is an abbreviated version of the application certification standards that every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. pt. 424, sec 424.57(c) and were effective on December 11, 2000.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or nonprocurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare-covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, or cell phone is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare-covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e. the supplier may not sell or allow another entity to use its Medicare Supplier Billing Number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). Implementation date- May 4, 2009

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BENEFICIARY REPAIR, REPLACEMENT AND RETURN 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.

I also understand that custom fabricated orthoses are made specifically for me, therefore they cannot be returned for a refund.

_____ _____
PATIENT NAME **DOB**

_____ _____
SIGNATURE **DATE**

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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 ____

What is the best daytime phone number you can be reached at? _____

Any other comments?
_____
_____
_____
_____

Thank you,

Advanced Therapy Center

_____ _____
PATIENT NAME **DOB**

_____ _____
SIGNATURE **DATE**

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Effective January 1st, 2013, Medicare is requiring Mandated Reporting of Patient Functional Status. In order to be compliant with Medicare requirements, at *Advanced Therapy Center*, we are utilizing the standardized Self-report Outcome Measure titled The Upper Limb Functional Index (ULFI). Periodically during the course of your care, we will be asking you to complete the brief questionnaire below in order to document your functional status and reported progress.

Since Advanced Therapy Center is a Medicare provider, we thank you in advance for assisting us with mandated Medicare requirements. (*If you need help in filling out the form, please don't hesitate to ask a staff member for assistance)*

UPPER LIMB FUNCTIONAL INDEX (ULFI)

PATIENT NAME: _____ DOB: _____ DATE: _____

Your upper limb (arm) may make it difficult to do some of the things you normally do. This list contains sentences people often use to describe themselves when they have such problems. Think of yourself over the last few days.

If an item describes you, mark the box. If not, leave the box blank.

DUE TO MY ARM:/(INJURED AREA) **Left Arm** **Right Arm**

- ❑ 1. I stay at home most of the time.
- ❑ 2. I change position frequently for comfort.
- ❑ 3. I avoid heavy jobs ie. cleaning, lifting more than 5kg or 10 lbs, gardening etc.
- ❑ 4. I rest more often.
- ❑ 5. I get others to do things for me.
- ❑ 6. I have pain almost all the time.
- ❑ 7. I have difficulty lifting and carrying (ie. bags, shopping up to 5kg or 10lbs).
- ❑ 8. My appetite is now different.

- ❑ 9. My walking or normal recreation activity is affected.
- ❑ 10. I have difficulty with normal home or family duties and chores.
- ❑ 11. I sleep less well.
- ❑ 12. I need assistance with personal care ie. washing and hygiene.
- ❑ 13. My regular daily activities (work, social contact) are affected.
- ❑ 14. I am more irritable and/or bad tempered.
- ❑ 15. I feel weaker and/or stiffer.
- ❑ 16. My transport independence is affected (driving, public transport).
- ❑ 17. I have difficulty putting my arm into a shirt sleeves or need assistance dressing.

- ❑ 18. I have difficulty writing or using a keyboard and/or "mouse".
- ❑ 19. I am unable to do things at or above shoulder height.
- ❑ 20. I have difficulty eating and/or using utensils (ie. knife, fork, spoon, chop sticks).
- ❑ 21. I have difficulty holding and moving dense objects (ie. mugs, jars, cans).
- ❑ 22. I tend to drop things and/or have minor accidents more frequently.
- ❑ 23. I use the other arm more often.
- ❑ 24. I have difficulty with buttons, keys, coins, taps/faucets, containers or screw-top lids.
- ❑ 25. I have difficulty opening, holding, pushing or pressing (ie. triggers, lever, heavy doors).