Associated Therapeutics, Inc.

Patient Information Form

Patient Information

Last Name ____________ First Name ____________ MI ____ SSN ____________

Address ____________

Address2 ____________ City ____________ State ____ Zip ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Date of Birth ____________ Marital Status ____________ Email ____________

Emergency Contact

Last Name ____________ Relationship ____________

First Name ____________ Phone ____________

Employer

Name ____________ Phone ____________

Address ____________

City ____________ State ____ Zip ____________

Problem

Problem Description ____________ Date of Injury ____________ Last Physician Visit / /

Referred By ____________ Primary Care Physician ____________

Latest Referral Information ____________ Motor Vehicle Accident ____

Latest Plan of Care ____________ That occurred in: ____

Notes: ____________

Primary Insurance

Insurance ____________ Deductible ____________ *Subscriber*

ID ____________ Max Benefit ____________ Name ____________

Group # ____________ CoPay ____ CoInsurance ____________ Relationship ____________

Date of Birth ____________

Secondary Insurance

Insurance ____________ Deductible ____________ *Subscriber*

ID ____________ Max Benefit ____________ Name ____________

Group # ____________ CoPay ____ CoInsurance ____________ Relationship ____________

Date of Birth ____________

Tertiary Insurance

Insurance ____________ Deductible ____________ *Subscriber*

ID ____________ Max Benefit ____________ Name ____________

Group # ____________ CoPay ____ CoInsurance ____________ Relationship ____________

Date of Birth ____________

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: ____________ Date: ____________

ASSOCIATED THERAPEUTICS, INC.
MEDICAL CHECK LIST

Previous surgeries (please list dates when possible):______________________________

____

Please check any of the following health problems you have or have had:

( ) Alzheimer's
( ) Arthritis: _____ Degenerative _____ Fibromyalgia
_____ Osteoarthritis _____ Rheumatoid

( ) Brain disorder, seizures, or epilepsy
( ) Cancer/tumors/cysts/growths/Hodgkin's Disease: _____benign _____ malignant
( ) Current pregnancy
( ) Diabetes: _____ insulin dependent _____ non-insulin dependent
( ) Drug or alcohol abuse habit
( ) Gastrointestinal tract condition/disease (list any): ______________________________

____

( ) Gynecological problems (list any): ______________________________

____

( ) Hearing loss
( ) Heart condition/disease (list any): ______________________________

____

( ) Hepatitis: ____A _____B _____C
( ) High blood pressure:_____controlled with medication
( ) HIV/ARC/AIDS
( ) Leukemia, hemophilia, or other blood disorders
( ) Mental or emotional disorder/depression
( ) Nervous system disorder: _____ Cerebral Palsy _____ Parkinson's disease
_____ Multiple Sclerosis _____ Muscular Dystrophy _____ Other

( ) Orthopedic injuries (joints, back, neck, etc.): ______________________________

____

( ) Respiratory/ lung conditions: _____Asthma ____COPD ____Emphysema ____Tuberculosis
( ) Stroke or transient ischemic attach
( ) Urinary tract, liver, kidney, bladder condition/disease
( ) Visual problems/deficits

Please list any other medical conditions that we should be aware of: ____________________

____

Do you currently exercise? ______________________________

PATIENT SIGNATURE: ______________________________ **DATE:**____________

MEDICATIONS LIST

Patient Name:______________________________ Date:__________

Medication: ______________________ Prescribed For: ______________________

Medication	Prescribed For

Medical Information Release Form

(HIPAA Release Form)

Name: ________________________________ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____________________________________

[ ] Child(ren)_________________________________

[ ] Other_____________________________________

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________________

The best time to reach me is (*day*)__________________ between (*time*)__________

Signed: ____________________________________ Date: ____/____/_____

Witness:____________________________________ Date: ____/____/______

Associated Therapeutics, Inc.
NOTICE OF PATIENT INFORMATION PRACTICES

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

ASSOCIATED THERAPEUTICS, INC.'S LEGAL DUTY

Associated Therapeutics, Inc. is required by law to protect the privacy of your protected health information, provide this notice about our information practices, and follow the information practices, effective April 1, 2003, that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Associated Therapeutics, Inc. uses your protected health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; and evaluating the quality of care that we provide. For example, Associated Therapeutics, Inc. may use your protected health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you.

Associated Therapeutics, Inc. may also use or disclose your protected health information without prior authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide information when required by law.

In any other situation, Associated Therapeutics, Inc.'s policy is to obtain your written authorization before disclosing your protected health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

We reserve the right to change our policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your protected health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your protected health information for reasons other than treatment, payment, or other related administrative purposes.

CONCERNS AND COMPLAINTS

If you are concerned that Associated Therapeutics, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your protected health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Associated Therapeutics, Inc.'s health information practices, or if you have a complaint, please contact:

Thomas J. Kelly, PT
Associated Therapeutics, Inc.
2704 Mineral Springs Road
Knoxville, TN 37917
Telephone: 865-687-4537
Fax: 865-687-5367

ASSOCIATED THERAPEUTICS, INC.
PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Associated Therapeutics, Inc.'s Notice of Information Practices. I understand that Associated Therapeutics, Inc. may use or disclose my protected health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my protected health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Associated Therapeutics, Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my protected health information for purposes as noted in Associated Therapeutics, Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

____

Patient Name

____

Patient Signature

____

Date

☐ I also authorize Associated Therapeutics, Inc. to use my protected health information for target marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

ASSOCIATED THERAPEUTICS, INC.
2704 MINERAL SPRINGS AVENUE
KNOXVILLE, TN 37917
PHONE: 865-687-4537/FAX: 865-687-5367

I understand that Medicare will not pay for outpatient physical therapy while I am receiving home health physical therapy. Therefore, I acknowledge that **I am not currently receiving home health physical therapy, and I will not begin home health physical therapy during my course of treatment at Associated Therapeutics, Inc.**

____ ______________________

Patient's Signature Date

I understand that even though I have Medicare Insurance, it will not pay for <u>all</u> physical therapy charges. If I do not have a supplemental insurance, or if Medicaid is that supplement and I do not have the part of Medicaid that pays for therapy (QMB), I will have a copay that I am responsible for at each visit.

____ ______________________

Patient's Signature Date

EXTENDED PAYMENT REQUEST

(Authorization for Medicare and your secondary insurance to pay Associated Therapeutics, Inc. for your services.)

Patient's Name (please print)______________________ Medicare #________________

I request that payment of authorized benefits by Medicare and/or my secondary insurance (____________________) be made either to me or on my behalf to Associated Therapeutics, Inc. for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Center for Medicare Services (CMS) and its agents, and my secondary insurance, any information needed to determine these benefits or the benefits payable for related services.

____ ______________________

Patient's Signature Date

ASSOCIATED THERAPEUTICS, INC.
APPOINTMENT POLICY

Your doctor has written a very specific prescription for physical therapy. Associated Therapeutics, Inc. is committed to helping you achieve maximum improvement in your condition. **When an appointment is scheduled for you at our facility, you are our number one priority during that time. We do not double book our patients; therefore, your reserved spot on our schedule is there just for you.** Arriving late, last minute cancellations, and no-shows impact your achieving maximum improvement through the benefits of physical therapy and they make it difficult to serve other patients who are in need of physical therapy appointments. We value the opportunity to help patients and provide a high level of quality care. We are a very busy practice and we want to be considerate to all our patients and their needs. For these reasons, we are asking that you share in our commitment to your physical therapy program and attend all appointments as scheduled.

- If you are unable to attend one of your appointments, please provide 24 hours notice. To ensure your condition does not regress, it is advised that you reschedule the missed appointment on a different day that week.
- If you miss 3 scheduled appointments, you will be removed from the schedule and a notice will be sent to your referring physician. We understand there are legitimate life events that occur, and we will take these into account.
- If you are going to be late for an appointment, please notify us so that we can adjust our schedule accordingly. Please understand we will try to administer your full treatment; however, time restraints may limit us from doing so.

We greatly appreciate your cooperation and look forward to helping you reach your therapeutic goals. Thank you for choosing Associated Therapeutics, Inc.

I acknowledge that I have read Associated Therapeutics, Inc. Appointment Policy.

______________________________ ______________________

Patient's Signature Date

ASSOCIATED THERAPEUTICS, INC.

PAYMENT FOR SERVICES RENDERED

As a courtesy to our patients, we will perform the initial insurance verification, complete any necessary reports, and file them with your insurance company. Because of the variability among insurance group policies, *it is your responsibility, and not that of Associated Therapeutics, Inc., to understand your "Outpatient Physical Therapy" benefit with your insurance plan.*

Below is the information we received from your insurance company concerning your benefits:

Effective Date______________
Deductible______________
Applied to Deductible______________
Out of Pocket______________
Applied to Out of Pocket____________
Copay____________
Coinsurance____________
Calendar Year Visits Allowed___________
Calendar Year Visits Used____________

If your insurance company responds on their Explanation of Benefits (EOB) in a different manner than what we have been told by them, the EOB will prevail. You will also receive a copy of your EOB from your insurance company. We encourage you to review each EOB as it will help you understand any billing you may receive from us.

This is not a guarantee of benefits. I understand that Associated Therapeutics, Inc. files my insurance as a courtesy, but does not accept responsibility for any misinformation we receive. I am responsible for negotiating the settlement of any disputed claims for all charges, regardless of anticipated insurance coverage.

I understand that my account is considered delinquent if over 60 days old and may be sent to an outside source for collection. I agree to pay the additional 35% collection cost and/or any attorney fees associated with collecting my delinquent account.

____ ________________________

Patient's Signature Date

Associated Therapeutics, Inc.

is a

FRAGRANCE FREE FACILITY.

In consideration of Patients/Employees who have Sensitive Allergies, please refrain from wearing Perfumes, Colognes, and Scented Lotions in this facility.

Thank you!