ADVANCE THERAPY CENTER

**PATIENT REGISTRATION FORM** (Please Print)

Patient Name (Last) _____ (First) _____ (M) _____

D.O.B. _____ S.S.N. (Four last digit) _____ Phone: _____

Address_____ City_____ State_____ Zip_____

Email Address: _____

Know Allergies: _____Date of injury/ Illness: _____ or Surgery Date: _____

Sex: Male ☐ Female ☐

If Female, are you currently or could you be pregnant? YES ☐ NO ☐

Last menstrual period (if applicable): _____

How many times have you been pregnant? _____

Number of Children: _____

**IN CASE OF EMERGENCY:**

Name _____Relationship_____Phone_____

Patient Signature: _____ Date: _____

*All authorizations must be signed by the patient or an authorized person in the case of a minor or when the patient is physically or mentally incompetent.

ADVANCE THERAPY CENTER

## MEDICAL HISTORY

| | You | | |
|---|---|---|---|
| | YES | NO | If YES, describes: |
| Arthritis | ☐ | ☐ | _____ |
| Asthma | ☐ | ☐ | _____ |
| High Blood Pressure | ☐ | ☐ | _____ |
| Cancer | ☐ | ☐ | _____ |
| Circulation | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ |
| Heart Disease | ☐ | ☐ | _____ |
| Liver | ☐ | ☐ | _____ |
| Lungs | ☐ | ☐ | _____ |
| Migraine | ☐ | ☐ | _____ |
| Stroke | ☐ | ☐ | _____ |
| Thyroid | ☐ | ☐ | _____ |
| Tuberculosis | ☐ | ☐ | _____ |
| Do you Smoke? | ☐ | ☐ | _____ |
| Substance abuse | ☐ | ☐ | _____ |
| Use illicit drugs? | ☐ | ☐ | _____ |
| Consume Alcohol? | ☐ | ☐ | _____ |
| HIV positive? | ☐ | ☐ | _____ |

Other: _____

_____

_____

***I certify that the above information is correct***

Patient Signature: _____ Date: _____

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THERAPY CENTER

## CONSENT FOR TREATMENT

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The undersigned has been informed of the treatment considered necessary for the patient whose name appears below and the treatment and procedures will be performed by physicians and employees of the above facility.

Authorization is hereby granted for such treatment, procedures and the administration of anesthetics. Medications or other therapies that may be deemed necessary.
I consent for myself or in behalf of the patient the selection, assignment of physician and agree to make arrangement with him for obtaining a complete diagnosis and continuation of treatment as needed.

I certify that I have the above authorization and understand it. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained by this treatment.

Patient's printed name: _____

Patient Signature: _____ Date: _____

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**NOTICE OF PRIVACY PRACTICES**

This **Notices** describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Dear Patient:

It is the desire of **Advance Therapy Center** to communicate to you that by definition of our practice procedures, we will follow HIPPA (Health Insurance Portability and Accountability Act) confidentiality laws. We do want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.
The most significant variable that has motivated the Federal Government to legally enforce the importance of the privacy of the health information is the rapid evolution of computer technology and its use in healthcare. The Government has appropriately sought to standardize and protect privacy of the electronic exchange of your health information. We want you to know about the policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it.

**How your Health Information may be utilized:**

We will use and communicate your Health Information ONLY for the purpose of providing treatment, obtaining payment and conducting healthcare operations, to run our practice more efficiently and ensure all our patient receive quality care, for research, to avert a serious health or safety treat , for organ and tissue donation, for worker's compensations programs, and in response to certain requests arising from lawsuits or disputes, as required by US Food & Drug Administration, other healthcare providers, treatment activities, or payment activities, uses and disclosures required by law, health oversight activities, and other public health activities. Your Health Information will not be used for other purposes unless we have asked for and been voluntarily given written permission.

**To Provide Treatment:**

**Advance Therapy Center**, will utilize your Health Information to provide you with the best cure possible. This may include administrative procedures designed to optimize scheduling and coordinating your care between therapists and administrative offices. In addition, we may share your Health Information with referring physicians or other healthcare personnel providing you treatment.

_____
Initial Here

**To Obtain Payment:**

**Advance Therapy Center** may include your health information and documentation with an invoice or claim form to collect payment from your or a third party for treatment you received from our Practice.

To Conduct Health Care Operations, health information may be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during routine processes of certification, licensing or credentialing.

Receive direct payment check(s) for benefits due to me for the services rendered by **Advance Therapy Center**, regardless of insurances benefits, if any. I unconditionally understand that I am financially responsible for the fees for services rendered.

**Patient Reminders:**

**Advance Therapy Center** believes in providing optimum care. We may call to remind you of your scheduled appointment. We will either speak with you directly OR leave a message on your voicemail. This communication is an important part of our philosophy of partnering with our patients to insure you receive the best care we can provide.

And understand that in the event I cannot attend my scheduled appointment for services to be rendered, then it is my sole responsibility to contact **Advance Therapy Center**, no later than twenty four (24) hours of my appointment date and time and either cancel or reschedule accordingly, otherwise a **twenty five dollars ($ 25)** no show fee will be assessed to me. I further understand that failure to do on three (3) consecutive occasions may cause **Advance Therapy Center**, to discontinue any further treatment and discharge me.

**Public Health, Safety and Law Enforcement:**

We may be required to disclose to Federal officials' or Law enforcement, health information necessary to complete investigation related to public health or national security.

_____
Initial Here

**Family, Friends & Caregivers:**

Advance Therapy Center may share your health information with those you tell us will be helping you at home. In the case of emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it is important to those participating in your care.

**Authorization to Use & Disclose Health Information:**

Other than what is stated above or where the Federal, State of Florida, or local law requires us, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

**Patient's Rights:**

You have the right to request that we communicate with you in a preferred method. You may request that we only communicate your health information privately with no other family member present OR through mailed communication that are sealed. We will make every effort to comply with your request (s). We reserve the right to deny a request if it imposes an unreasonable burden on our Practice.

**Inspect & Copy your Health Information:**

You have the right to read, review, and copy your health information, including your chart and billing records. We may need to charge you a reasonable fee, based upon Florida Statute(s), a reasonable fee to duplicate and assemble your copies.

We will maintain the privacy of your health information and provide you and your representative this Notice of Our Privacy Practices. We are required to practice policies and procedures described in this notice, but we deserve the right to change the terms of this Notice. If we change our privacy practice, we will be sure patients receive a copy of the revised Notice.

I acknowledge that I have read and/or received the Notice of Privacy Practices.

Patient Name: _____

Patient Signature: _____ Date: _____

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