PATIENT REGISTRATION

Welcome to American Therapy Centers, LLC. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Last 4 Digits Social Security #	Address	City State	Zip
Home Phone / Cell Phone	Email Address:		
Person financially responsible for this account	Relationship to Patient	Responsible Party's Phone Number	
Responsible Party's Birthdate ____/____/_____	Last 4 Digits Social Security #	Responsible Party Driver's License #	State:
Primary Care Physician	Phone Number	**Referring Physician**	Phone Number
Occupation	Name of Employer	Address or ___ Not Applicable	Business Phone
Do you have any allergies?	Are you currently taking any medications?		
Person to contact in case of emergency	Relationship to Patient	Phone Number	

Medicare Yes [ ] No [ ]	Medicare #	Medicaid Yes [ ] No [ ]	Medicaid #	Effective Date
Medicare Secondary Insurance	Address		Policy #	Group #

Workers' Compensation? Yes [ ] No [ ] Motor Vehicle? Yes [ ] No [ ] **If Yes, indicate carrier below**	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #
Primary Insurance Company	Address			
Subscriber Name	Contract #	Policy #	Group #	
Secondary Insurance (if any)	Address		Policy #	Group #

MEDICARE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf to American Therapy Centers.

_____ _____

Signature of Patient or Responsible Party **Date**

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE:

I authorize payment of medical benefits to American Therapy Centers for any professional services furnished me by American Therapy Centers. I understand that I am financially responsible for any amount not covered by this assignment. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Signature of Patient or Responsible Party **Date**

American Therapy Centers, LLC

Specializing in Pulmonary & Physical Rehabilitation

Patient Name:_____ _____Date:_____

STATEMENT OF FINANCIAL RESPONSIBILITY

American Therapy Centers, LLC appreciates the confidence you have shown in choosing us to provide your rehabilitation needs. The services you will receive may have a financial responsibility on your part with regard to deductibles/co-insurance or copayments. As a courtesy, we will verify and bill your insurance carrier on your behalf; however, you are ultimately responsible for the payment of your bill.

Copayments are due at the time of service unless you have made other arrangements with American Therapy Centers, LLC. You are responsible for payment of deductible or co-insurance as determined by your contract with your insurance carrier on receipt of a bill from American Therapy Centers, LLC. If your insurance carrier denies any part of your claim or if you and your physician elect to continue therapy past your approved period, you are responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to American Therapy Centers, LLC. I certify that the information I provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to American Therapy Centers, LLC. and I agree to pay the entire amount of all bills incurred by me or the above named patient.

Signature_____(self; guardian, other)_____Date:_____

DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize American Therapy Centers, LLC to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons may include: spouse, children, blood relatives and domestic partners. If you do not wish to have health information disclosed please write NO DISCLOSURE in the chart below.

NAME	RELATIONSHIP

Signature:_____Date:_____

I acknowledge that the **Notice of Privacy Practices** is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have a right to request a copy of the notice and one will be provided to me.

Signature:_____Date:_____

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize American Therapy Centers, LLC through its appropriate personnel, to furnish medical care and treatment to me or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

I further authorize American Therapy Centers, LLC to release to appropriate agencies, any information in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature:_____Date:_____

Medical History Form

Patient Name: DOB:

Height: ft in Weight: lbs Date of Injury/Onset of Symptoms:

Diagnosis as stated to you by your physician:

How did this injury/exacerbation occur?

Have you been hospitalized for the present ▫ YES ▫ NO If yes, date:

Have you had surgery for the present ▫ YES ▫ NO If yes, date:

If yes, surgery type:

Have you had any falls this past year? ▫ YES ▫ NO If yes, how many?

Have you received previous treatment for this ▫ YES ▫ NO If yes, date:

If yes, summarize:

Have you had a flu vaccine? ▫ YES ▫ NO If yes, date:

Have you had a pneumonia vaccine? ▫ YES ▫ NO If yes, date:

Have you ever had any of the following: ▫ EMG ▫ CT SCAN ▫ MYELOGRAM ▫ MRI ▫ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Acquired Respiratory Distress Syndrome	▫ YES	▫ NO	Allergies	▫ YES	▫ NO
Angina	▫ YES	▫ NO	Headaches	▫ YES	▫ NO
Anxiety or Panic Disorders	▫ YES	▫ NO	Back Injury	▫ YES	▫ NO
Arthritis (RA, OA)	▫ YES	▫ NO	Bleeding Disorders	▫ YES	▫ NO
Asthma	▫ YES	▫ NO	Bowel/Bladder Abnormalities	▫ YES	▫ NO
Chronic Obstructive Pulmonary Disease (COPD)	▫ YES	▫ NO	Cancer	▫ YES	▫ NO
Congestive Heart Failure (CHF)	▫ YES	▫ NO	Dizzy or Fainting Spells	▫ YES	▫ NO
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	▫ YES	▫ NO	Epilepsy or Seizure Disorder	▫ YES	▫ NO
Depression	▫ YES	▫ NO	Fracture	▫ YES	▫ NO
Diabetes	▫ YES	▫ NO	Hepatitis A, B, C	▫ YES	▫ NO
Emphysema	▫ YES	▫ NO	Hernia	▫ YES	▫ NO
Hearing Impairment	▫ YES	▫ NO	High Blood Pressure	▫ YES	▫ NO
Heart Attack	▫ YES	▫ NO	Hypoglycemia	▫ YES	▫ NO
Multiple Sclerosis	▫ YES	▫ NO	Immunosuppressant Condition or Medication	▫ YES	▫ NO
Osteoporosis	▫ YES	▫ NO	Kidney Problems	▫ YES	▫ NO
Parkinson's Disease	▫ YES	▫ NO	Liver/Gallbladder Problems	▫ YES	▫ NO
Peripheral Vascular Disease	▫ YES	▫ NO	Metal Implants	▫ YES	▫ NO
Stroke or TIA	▫ YES	▫ NO	Nausea/Vomiting	▫ YES	▫ NO
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	▫ YES	▫ NO	Pacemaker	▫ YES	▫ NO
Visual Impairment (cataracts, glaucoma, macular degeneration)	▫ YES	▫ NO	Pregnancy	▫ YES	▫ NO
Other:	▫ YES	▫ NO	Ringing in your ears	▫ YES	▫ NO
	▫ YES	▫ NO	Sexual Dysfunction	▫ YES	▫ NO
	▫ YES	▫ NO	Skin Abnormalities	▫ YES	▫ NO
	▫ YES	▫ NO	Smoking	▫ YES	▫ NO
	▫ YES	▫ NO	Special Diet Guidelines	▫ YES	▫ NO
	▫ YES	▫ NO	Tuberculosis	▫ YES	▫ NO

Medications:

Please list medications, dosage, frequency below or provide a medication list
