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 [ ]
Address City State Zip	Home Phone		Patient's Social Security #
Person financially responsible for this account	Relationship to Patient	Responsible Party's Birthdate ____/____/_____	Responsible Party's Social Security #
Responsible Party Drivers License # State: Number			**Primary Care Physician**
Name of Employer Address or ___ Not Applicable	Business Phone		Occupation
Do you have any allergies?	Are you currently taking any medications?		
Person to contact in case of emergency	Relationship to Patient	Phone	

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**

Patient Name: Date of Birth:
Date of Service:

INFORMED CONSENT FOR TREATMENT/PROCEDURE

PROPOSED PROCEDURE/TREATMENT: ______________________________

I acknowledge that ______________________ has informed me of the following:

1. My diagnosis, if known
2. My basic rights and responsibilities as a patient
3. The nature and details of the procedure/treatment
4. The purpose of the procedure/treatment
5. The potential risks of the procedure/treatment
6. The potential benefits of the procedure/treatment
7. The alternatives available, if any
8. The risks and benefits of the alternatives
9. The potential risk if the procedure/treatment is not performed

I acknowledge that I have had an opportunity to ask all the questions I have regarding this condition or disease and concerning the available treatments and/or procedures. All questions have been answered to my satisfaction.

I acknowledge that no guarantees, either express or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding a cure or outcome of any medical treatment or procedure.

I hereby authorize the above-named provider and designated associates and assistants to perform the treatment or procedure named above.

______________________________ ______________________________
Authorized Signature Date

______________________________ ______________________________
Witness Date

Patient Name: Date of Birth:
Date of Service:

Patients' Rights and Responsibilities

At American Therapy Centers we are committed to serving you with compassion, care, skill, and respect. Our policy is to respect the individuality and dignity of all patients, and to honor in accordance with law, an adult patient's right to make decisions regarding treatment. This includes the adult patient's right to consent to, refuse, and/or alter treatment plans.

YOU HAVE THE RIGHT:

- To receive fair and humane treatment and you will not be denied access to treatment or accommodations that are medically indicated on the basis of race, sex, age, creed, national origin, disability or source of payment for care;
- To privacy regarding the information necessary for medical care, the privacy of your body, and the right to expect all communications and records pertaining to your care to be treated as confidential;
- To know the effectiveness, possible side effects and problems of all forms of treatment;
- To receive education and counseling;
- To talk with the team of professional staff responsible for your care and to receive information necessary to understand your medical problem and planned treatment;
- To participate in decisions regarding your care including treatment plans and the right to refuse or withhold care;
- To receive an explanation of your bill and to request estimated charges for routine services or procedures;
- To reasonable attention to complaints and grievances when communicated to any member of the health care team and the freedom to voice such concerns without fear or reprisal or compromise of care;
- To file a grievance concerning the physician, staff, office, and treatment received; you may call your State Omsbudman at (800) 282-6006 from 8:00 am – 5:00 pm, Monday through Friday (voice mail on off hours) with such complaint.

YOU HAVE THE RESPONSIBILITY:

- To provide accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health;
- To ask questions when you do not understand what you have been told about your health care and what you are expected to do;
- To follow the treatment plan developed with your practitioner and if you refuse treatment or fail to follow the practitioner's instructions, you are responsible for the outcomes;
- To report any significant changes in symptoms or failure to improve;
- To follow health advice and medical instructions;
- To keep appointments or cancel in advance;
- To follow and have your family follow the clinic's rules and regulations concerning patient care and conduct.

__________________________________ __________________
Patient Signature Date

Patient Name: Date of Birth:
Date of Service:

Notice of Privacy Practices

I have read, understand, and/or received a copy of American Therapy Center's (35180 Nankin Blvd.,Suite 205, Westland, MI., 48185), Notice of Privacy Practices. I understand that I have access to my protected health information and how this information may be used and disclosed.

I can contact the Clinic Manager should I have any concerns at 734-261-4848.

_________________________ Date:_____________
Signature of Patient/Guardian

____
Relationship to Patient

__________________________ Date:_______________
Witness

Patient Name:

Date of Birth:
Date of Service:

AMERICAN THERAPY CENTERS, LLC

Records Release / Authorization

TO: ____

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I hereby authorize and request you to release records to:

American Therapy Centers, LLC
7107 N. Wayne Rd.
Westland, MI 48185
(734) 728-5660

Records Requested:

- The patient's significant medical history;
- Current medical findings;
- Diagnosis(es) and contraindications to any treatment modality;
- Rehabilitation goals, if determined

Name of Patient: ____
Social Security Number: ____
Date of Birth: ____
Address: ____
City, State, Zip: ____

____ ____________________
Patient/Responsible Party Date

____
Relationship to Patient if Signed by Responsible Party

This release is valid 6 months from the date of signature

Patient Name: Date of Birth:
Date of Service:

Dear Patient:

Due to the many changes in insurance policies, it is no longer a simple task to interpret each individual policy. Although we try to stay aware of these changes and verify eligibility; it is not always possible. Therefore, we urge you to check your benefits with your insurance company. It is the patient's responsibility to know and understand their individual coverage. Please remember your insurance policy is between you and your insurance company.

Thank you,

American Therapy Centers

Signature: ________________________________ Date: __________________

7107 N. Wayne Rd. * Westland, MI 48185 * Office (734) 728-5660 * Fax (734) 728-5670