Welcome to Advantage Integrated Therapy Centers. Your physician has referred you to physical therapy to assist in your healing and recovery. In order for us to most effectively assist you on the road to recovery, the following guidelines and policies have been implemented.

- Clothing: For future visits, please wear loose, comfortable clothing, including sneakers.
- Attendance: To assist you in your care, consistent and timely attendance to your physical therapy is extremely important. If you must cancel, please call prior to your appointment. (Appropriate phone numbers found on letter head above). To avoid a $10.00 cancellation fee, please call 24 hours in advance, or, be sure to reschedule your appointment within the same week. If you are more than 15 minutes late for you appointment, it may be necessary to reschedule. If you do miss a physical therapy appointment without notice, your visit will be considered a "no show". In this case, Advantage Integrated Therapy Centers reserves the right to charge a $20.00 no show fee. If you miss more than 2 physical therapy appointments, you may be discharged from physical therapy. If your visits are being filed under Worker's Compensation or Short Term Disability, please be aware that your claim may be jeopardized if you miss appointments without justifiable cause.
- Cell Phones: Except in emergency situations, please keep cell phones off or on vibrate mode as your therapist will require your full attention.
- Children: For your child's safety, please do not bring your children to physical therapy. We do realize that occasional situations may arise in which you must bring your children, but it should not be a common occurrence.
- Insurance: As a courtesy to you, we bill your insurance company for the services you receive at Advantage Integrated Therapy Centers. However, any co-insurance and or co-pays are due at the time of service.

  (PLEASE NOTE: Estimates for deductible and coinsurance are only ESTIMATES. There may be a balance/refund due depending on the actual payment from your insurance company.)

  We will also verify your benefits for our services however; this is not, a guarantee. Please see receptionist regarding rules on auto claims.

If you have any questions or concerns regarding these policies and guidelines, please feel free to ask your physical therapist or the front desk staff. We are certain this will be a mutually rewarding experience and we look forward to assisting you in attaining your goals.

Sincerely,

The Staff of Advantage Integrated Therapy Centers

I acknowledge I have read and understand the above information.

______________________________ ____________________

Patient Signature Date

ADVANTAGE
Integrated Therapy Centers

First:__________ M.I.: _____ Last:__________ Age:_____

Date of Birth:__________ Social Security Number:____ - ____ - ____ Sex: M F

Home Address:__________

City:__________ State:_____ Zip:____ - ____

Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Work Phone: (____) ____ - ____

Email Address:__________

Employer:__________ Occupation:__________

Name of Spouse:__________ His/Her Employer: __________

Emergency Contact: __________ Phone:__________

How did you find out about us?__________

Referring Physician:__________

NAME ADDRESS PHONE

Date of injury / Date of onset:__________ Is this the result of an accident? Y N

If yes, what type of accident? AUTO / WORK / OTHER:__________

Insurance Information:

Primary Carrier: __________ Secondary Carrier:__________

Insured:__________ Insured:__________

Insured's Date of Birth:__________ Insured's Date of Birth:__________

ID#:__________ ID#:__________

Phone:__________ Phone:__________

Assignment / Release / Consent:

I certify that I, and/or my dependent(s), have insurance coverage with__________
And assign directly to Advantage Integrated Therapy Centers all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Advantage Integrated Therapy Centers may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

By signing this form, I give Advantage Integrated Therapy Centers consent to treat me or my dependent(s)

__________ __________

Signature of Patient, Parent, Guardian Date

ADVANTAGE
Integrated Therapy Centers

Authorization - Compound

This authorization form permits: Advantage Integrated Therapy Centers to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name____ Birth Date________________

Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you.	Description of information to be given to checked Entity or Person.
Voice mail/ Text Cell phone#___________________	☐ Appointment time ☐ Financial Information ☐ Medical Information
Email messaging _______________________________	☐ Appointment time
Other (Provide name) _______________________________ _______________________________	☐ Appointment time ☐ Financial Information ☐ Medical Information

Purpose:
The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event:
This authorization shall be enforce until revoked by the patient.

Rights of the Patient
- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

____ ________________________

Signature of Patient or Personal Representative (as defined by HIPAA) Date

Description of Personal Representative's Authority (attach necessary documentation)

____

- -

Office use only:

Receiving Employee:_____________________________ Date received:_____________________________

☐ Copy given to patient if requested

ADVANTAGE
Integrated Therapy Centers

Health History

Name: ______________________ DOB:________Height: _________Weight: __________
Leisure activities (including Exercise routines) ______________________________________
Occupation: ____
Are you on a work restriction from your doctor? □Yes □No
Are you latex sensitive? □Yes □No Do you smoke? □Yes □No
Do you have a pacemaker? □Yes □No Are you pregnant or think you may be? □Yes □No

What brings you into our office today for evaluation? ______________________________________
How long have your symptoms been present?____________________ How did the problem occur?________________
Treatments received so far for this problem (chiropractic, injections, etc)______________________________

Please list any surgeries or other conditions for which you have been hospitalized, including dates: ______________________

____

Have you had any of the following tests performed for your current problem/condition (please include dates):
X-rays □ Yes □ No *Nerve conduction test* □ Yes □ No *EMG* □ Yes □ No
CT Scan □ Yes □ No *MRI* □ Yes □ No ______________________________________

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: _________________
The best your pain has been during the past week: _________________
The worst your pain has been during the past week:_________________

My symptoms currently: □Come and go □Constant □ Are constant, but change with activity.
What makes it worse? ____
What makes it better? ____

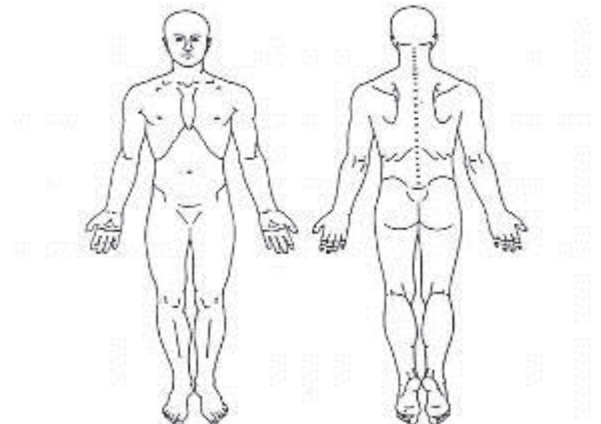
How are you currently able to sleep at night due to your symptoms?
□No problem sleeping □Difficulty sleeping □Awakened by pain □ Sleep only with medication

When are your symptoms worst? □Morning □Afternoon □Evening □Night □After exercise
When are your symptoms the best? □Morning □Afternoon □Evening □Night □After exercise

Have you ever had this problem before: □ Yes □ No When_________ Treatment received ____________________
How long did it take for you to feel better? ____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓ **Shooting/Sharp pain**
O **Dull/Aching pain**
× **Numbness**
= **Tingling**

ADVANTAGE
Integrated Therapy Centers

Health History

Allergies:
List any medications you are allergic to: ______________________________

Have you RECENTLY noted any of the following: (Check all that apply)

□fatigue □numbness or tingling □gout □fever/chills/sweats
□muscle weakness □nausea/vomiting □hernia □dizziness/lightheadness
□shortness of breath □fainting □difficulty maintaining balance while walking
□bone fracture/joint injury □falls □headaches

Have you EVER been diagnosed with any of the following conditions (Check all that apply)

□cancer- what type/when? ____________ □depression □heart problems □lung problems
□diabetes □chest pain/angina □tuberculosis □osteoporosis
□high blood pressure □multiple sclerosis □asthma □circulation problems
□rheumatoid arthritis □epilepsy □blood clots □other arthritic condition
□stroke □anemia □liver problems □bone or joint infection
□chemical dependency (i.e. alcoholism) □high cholesterol □pneumonia □hepatitis
□human immunodeficiency virus *(HIV)* □STD □Other ____________________

During the past month have you been feeling down, depressed or hopeless? □Yes □No
During the past month have you been bothered by having little interest or pleasure in doing things? □Yes □No
Is this something with which you would like help? □Yes □Yes, but not today □No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? □Yes □No

Please list any medication you are currently taking (including pills, injections, and/or skin patches): ____________________
____ ________(PT Initials)
Have you ever taken steroid medications for any medical conditions? □Yes □No
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? □Yes □No

Previous History of:

Physical Therapy:	□Yes	□No	Date: ____________________
Chiropractic:	□Yes	□No	Date: ____________________
Occupational Therapy:	□Yes	□No	Date: ____________________
Speech Therapy:	□Yes	□No	Date: ____________________
Home Health Care:	□Yes	□No	Date: ____________________
Other Therapy:	□Yes	□No	Date: ____________________

My signature verifies the above information is true and correct to the best of my knowledge.

____
Signature/Guardian Date

____
Physical/Occupational Therapist Signature Date

NOTICE OF PRIVACY PRACTICES

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

Uses and disclosures to carry out treatment, payment, and health care operations:

Treatment –
This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment –
This practice may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

Health care Operation –
This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate.

This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities.

This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

This practice may contact you for our own fundraising activities. If you do not want to receive fundraising communication, you may opt-out at any time. If you opt-out you will receive no further fundraising communications.

Authorized Uses or Disclosures:
The following uses or disclosures require a valid authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes –
Not applicable to this practice

Uses or Disclosures for Marketing Purposes –
Not applicable to this practice

Disclosures for a Sale of Protected Health Information –
This practice will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object:
For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required:
The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law –
This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities –
This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence -
This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities –
This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings –
This practice may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes –
This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents –
This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes – This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes –
This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety –
This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures for specialized government –
This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation –
This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA:
The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, except as discussed in the Right of Restriction section.

Right of an individual to request a restriction of uses and disclosures –
This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service

Confidential communication requirements –
This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information –
An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

Amendment of protected health information –
An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information –
An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will a reasonable cost based fee for additional requests.

Right of Breach Notification –
An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

Copy of this notice:
You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties:
This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices will be available and posted at our offices(s) and posted on our web site, if applicable.

Complaints:
If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact:
You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, and 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

The name and address of the person you can contact for further information concerning our privacy practices is:

HIPAA Privacy Officer:

Tabatha Ard
610-594-2060

Advantage Integrated Therapy Centers
983A E. Lancaster Avenue
Downingtown, PA 19335

Effective Date of the Notice is July 12, 2019

Acknowledgement of Receipt
Of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for the above named practice.

______________________________________ ______________________
Signature Date

Description of Personal Representative's Authority
(attach necessary documentation)

____

____

For Office Use Only

We were unable to obtain a written acknowledgement of Receipt of the Notice of Privacy Practices because:

☐ The individual refused to sign.

☐ Other:____

____

Employee preparing document:______________________________________

Employee Signature: ____

Date: ____________________