Advanced Therapy Center
3475 Torrance Blvd. #B2
Torrance, Ca. 90503
Patient Information Sheet

Patient Name _____ (M / F / NON-BINARY) DOB: _____ Age: ____
Home Address_____ City _____State:____ Zip _____
Home PH#:_____ Cell/Work/Other: _____
Email Address: _____
SSN#: _____ Employer: _____
Pronouns: She/Her , He/ Him , They/ Them , (Circle all that apply)

Married Divorced Single Minor / Child Widowed Separated

Primary Insurance Company Name: _____
ID / Subscriber Number #: _____ Group#: _____

- Have you had OT / PT / SP services this year? _____
- Are you currently receiving ANY home health services? _____

Private Health Insurance:
It is your responsibility to know the benefits and limitations of your particular insurance policy. For insurance companies that we do not contract with the services rendered with be your responsibility at the Usual & Customary rates for this area. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.

Twenty-four hours notification is requested when canceling an appointment. Thank you!

**A No-Show FEE of $60 will be due and payable for any appointments not cancelled within 24 hours

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from Advanced Therapy Center whether covered by insurance or not.

I have read, understand, and agree to the above stated financial policies. I consent to therapeutic treatment and services rendered, which include those modalities and/or procedures prescribed by my physician. I hereby state that the information I have provided is true and correct to the best of my knowledge.

Signature: _____ Date: _____

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

ADVANCED THERAPY CENTER
Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accounting Act of 1996 (HIPAA).

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

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, for other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day to day activities and management of Advanced Therapy Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include the following:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information
5. The right to receive accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of the notice

Right to Revise Privacy Practices
As permitted by law, we reserve the right amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting

Privacy Officer
Advanced Therapy Center
3475 Torrance Blvd STE B2,
Torrance, CA 90503.

Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____
PATIENT NAME DOB

_____ _____
SIGNATURE DATE

Complaints or Comments
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Advanced Therapy Center
3475 Torrance, Blvd STE B2
Torrance, CA 90503

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

ADVANCED THERAPY CENTER

MEDICAL HISTORY

_____ _____

PATIENT NAME DOB

_____ _____

SIGNATURE DATE

Do you have/ or had any of the following?

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Heart attack
- ☐ Pacemaker
- ☐ Headaches
- ☐ Kidney problems
- ☐ Nervous disorders
- ☐ Gout
- ☐ Joint replacement
- ☐ Do you smoke
- ☐ Arthritis/painful or swollen joints
- ☐ Dizziness/fainting
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Vision or hearing difficulties
- ☐ Difficulty sleeping
- ☐ Circulatory disorder
- ☐ Cancer or radiation/chemotherapy
- ☐ Sensitivity to heat
- ☐ Sensitivity to ice/ cold
- ☐ Numbness or tingling
- ☐ Previous surgery _____
- ☐ Seizures
- ☐ Metal implants or pins
- ☐ Previous joint injuries
- ☐ Emotional/Psychological Concerns
- ☐ Osteoporosis
- ☐ Embolism (blood clot)
- ☐ Stroke
- ☐ Currently pregnant
- ☐ Infectious disease
- ☐ Bowel or bladder issues
- ☐ Other _____

ALLERGIES_____

Pertinent medical history that could assist us in your care: _____
_____

Are you currently taking any medications? If so, please list: _____ _____
_____ _____

Are you currently having Therapy at another facility? _____

ADVANCED THERAPY CENTER
Financial Responsibility

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policies. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.

Private Health Insurance

If you have a co-payment, it is due at the time of treatment. As a courtesy, we will bill your insurance company on your behalf for services provided to you. If for any reason your insurance company does not cover the treatment; you will be financially responsible for payment at the usual & customary rates. Additionally: if your insurance company makes payment to you (personally), and not to our office, due to contractual obligations, you are ultimately responsible for the amount paid. *Verification of benefits is done as a courtesy and is never a guarantee of payment. Should you have any questions regarding your insurance coverage, we will gladly assist you; however, it is your responsibility to know the benefits and limitations of your particular insurance policy.

Twenty-four hours notification is requested when canceling an appointment. Thank you!
Missed appointments will be charged $60.00.

We reserve the right to discontinue treatment if you fail to comply with the policies stated above

Your Personal Benefits:

Deductible _____Co-Insurance _____Co-Payment _____ Max Visits _____ OP Max _____ Coverage: 100%, 90%, 80%, 70%, 60%, 50%, 40%

I have read, understand, and agree to the above stated financial policies. I consent to therapeutic treatment and services rendered here which include those procedures prescribed by my physician. I hereby state that the information I have provided is true and correct to the best of my knowledge.

Patient/Parent Signature: Dated:

_____ _____