

Patient Registration

Previous Patient ___Yes ___No

_____	_____	_____	_____	_____
Last Name	First Name	Age	Male	Female
_____	_____	_____	_____	_____
Street Address	City	State	Zip	
_____	_____	_____	_____	
Mailing Address (If different from above)	City	State	Zip	
(____) _____	(____) _____	_____		
Home Phone	Cellular Phone	E-Mail Address		
_____	(____) _____	_____		
Emergency Contact Person	Phone	If Minor, Parent/Legal Guardian Name		

Social Security Number ____-____-____ Date of Birth ____/____/____ Single ___ Married ___

Referring Physician _____ Primary Care Physician _____

Primary Insurance Name and ID Number: _____

Secondary Insurance Name and ID Number: _____

Have you received therapy in the past year either through another facility or through home healthcare? ___Yes ___No
If yes, please explain: _____

For Achievement Rehabilitation Pediatric patients, if applicable:

Child was placed in your home for foster care at the age of ____ on ____/____/____. Number of previous placements? ____

Formally adopted at the age of ____ on ____/____/____. Name(s) the child had prior to adoption: _____

Informed Consent

By signing below, you are hereby granting Achievement Rehabilitation Through Therapeutic Intervention, Inc (ARTTI) staff to perform therapeutic services. It is your right to accept or refuse any treatment offered. I understand that this care may include an evaluation and continuing treatment, based on the Plan of Care set by your evaluating therapist.

I understand the purpose of physical/speech/occupational therapy is to maximize my health potential through natural means and promote my ability to perform work, leisure/play and sports activities through increased strength, flexibility, agility, language, sensory-motor and movement strategies. It is not possible to predict the results or the outcome of treatment(s). Sometimes benefits are realized immediately and sometimes more gradual over time.

It is up to the patient/guardian/caregiver to inform the therapist/staff about any health problems or allergies the patient may have. Patient/guardian/caregiver must also tell the therapist/staff about any medications being taken as well as any medical conditions and/or surgeries. I understand that by signing this form, records of a confidential nature will only be released to the entities providing financial assistance or regarding authorization for my health care.

If the patient is a minor (under the age of 18), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

If the patient is a minor, I hereby authorize Achievement Rehabilitation Through Therapeutic Intervention, Inc (ARTTI) staff to secure medical treatment necessary for my child's welfare.

In addition, I give ARTTI permission to screen for other therapies, such as Behavioral, Occupational, Speech or Physical therapy.

Patient's Signature

Legal Guardian's Signature

Date

Patient Summary Form

Please complete this form to the best of your ability. Completion will assist us in delivering the best services possible and will assist us in gaining authorization from your insurance company.

Patient Information

Patient name Last First MI			<input type="radio"/> Female <input type="radio"/> Male		Patient date of birth		
Patient address				City		State	Zip code
Patient insurance ID#		Health plan		Group number			
Referring physician (if applicable)			Date referral issued (if applicable)		Referral number (if applicable)		

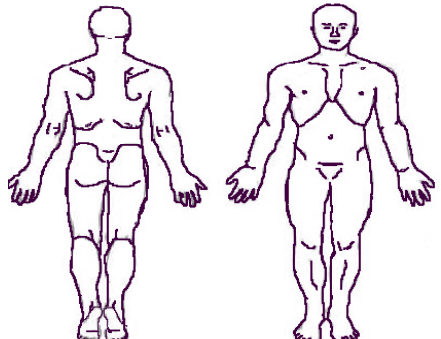
Provider Information

Achievement Rehabilitaton Through Therapeutic Intervention				270991521			
1. Name of the billing provider or facility (as it will appear on the claim form)				2. Federal tax ID(TIN) of entity in box #1			
3. Name and credentials of the individual performing the service(s) <input type="checkbox"/> 1 MD/DO <input type="checkbox"/> 2 DC <input type="checkbox"/> 3 PT <input type="checkbox"/> 4 OT <input type="checkbox"/> 5 Both PT and OT <input type="checkbox"/> 6 Home Care <input type="checkbox"/> 7 ATC <input type="checkbox"/> 8 MT <input type="checkbox"/> 9 Other _____							
4. Alternate name (if any) of entity in box #1				1275869513		352-419-6570	
5. NPI of entity in box #1							
7. Address of the billing provider or facility indicated in box #1					8. City	9. State	

Provider Completes This Section:

Date you want THIS submission to begin: <input type="text"/> <input type="text"/> <input type="text"/>		Cause of Current Episode <input type="radio"/> 1 Traumatic <input type="radio"/> 4 Post-surgical <input type="radio"/> 2 Unspecified <input type="radio"/> 5 Work related <input type="radio"/> 3 Repetitive <input type="radio"/> 6 Motor vehicle		Date of Surgery <input type="text"/> <input type="text"/> <input type="text"/>		Diagnosis (ICD codes) Please ensure all digits are entered accurately 1° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Patient Type <input type="radio"/> 1 New to your office <input type="radio"/> 2 Est'd, new injury <input type="radio"/> 3 Est'd, new episode <input type="radio"/> 4 Est'd, continuing care		Type of Surgery <input type="radio"/> 1 ACL Reconstruction <input type="radio"/> 2 Rotator Cuff/Labral Repair <input type="radio"/> 3 Tendon Repair <input type="radio"/> 4 Spinal Fusion <input type="radio"/> 5 Joint Replacement <input type="radio"/> 6 Other _____					
Nature of Condition <input type="radio"/> 1 Initial onset (within last 3 months) <input type="radio"/> 2 Recurrent (multiple episodes of < 3 months) <input type="radio"/> 3 Chronic (continuous duration > 3 months)		DC ONLY Anticipated CMT Level <input type="radio"/> 98940 <input type="radio"/> 98942 <input type="radio"/> 98941 <input type="radio"/> 98943		Current Functional Measure Score Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/> Back Index <input type="text"/> LEFS <input type="text"/> <input type="text"/> (other FOM)			

Patient Completes This Section:

Symptoms began on: <input type="text"/> <input type="text"/> <input type="text"/>		Indicate where you have pain or other symptoms: 	
1. Briefly describe your symptoms: _____ _____ _____			
2. How did your symptoms start? _____ _____			
3. Average pain/symptom intensity: Last 24 hours: Scale of 1 (minimal) to 10, with 10 being the worst: Past week: Scale of 1 (minimal) to 10, with 10 being the worst:			
4. How often do you experience your symptoms? <input type="radio"/> 1 Constantly (76%-100% of the time) <input type="radio"/> 2 Frequently (51%-75% of the time) <input type="radio"/> 3 Occasionally (26% - 50% of the time) <input type="radio"/> 4 Intermittently (0%-25% of the time)			
5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) <input type="radio"/> 1 Not at all <input type="radio"/> 2 A little bit <input type="radio"/> 3 Moderately <input type="radio"/> 4 Quite a bit <input type="radio"/> 5 Extremely			
6. How is your condition changing, since care began at this facility? <input type="radio"/> 0 N/A — This is the initial visit <input type="radio"/> 1 Much worse <input type="radio"/> 2 Worse <input type="radio"/> 3 A little worse <input type="radio"/> 4 No change <input type="radio"/> 5 A little better <input type="radio"/> 6 Better <input type="radio"/> 7 Much better			
7. In general, would you say your overall health right now is... <input type="radio"/> 1 Excellent <input type="radio"/> 2 Very good <input type="radio"/> 3 Good <input type="radio"/> 4 Fair <input type="radio"/> 5 Poor			

Patient Signature: X Date: _____

Informed Company Policies for a Successful Relationship

To Our Patients, Regarding Cancellations and No Call/No Shows:

The following are our policies regarding cancellations and no call/no shows. We take your treatment very seriously, as it can make a difference between whether or not you succeed in your treatment. Your referring physician or therapist prescribed a frequency of treatment and maintaining your scheduled visits is your highest priority.

We REQUIRE a minimum of 24 hours notice, in the event of a cancellation. It is your responsibility, when you call, to call during regular business hours and have an alternate time in mind that will ensure you attend the entire number of prescribed treatments each week.

For medicaid, workers' compensation and personal injury patients, documentation of any missed appointments will be communicated to your insurance, case manager and/or referring/primary care physician. This can jeopardize your claims and/or ability to get future authorizations for therapeutic services.

In an instance of a cancellation without 24 hours notice or no-call / no-show to a scheduled appointment, we charge a \$50 cancellation fee, which must be paid prior to attending future appointments.

Patients who have multiple same-day cancellations or no-shows will be removed from the active schedule and placed on our day-to-day list to avoid future last minute cancellations that keep other patients from care.

When you do not attend as scheduled, three people are hurt by your action:

1. *You* did not receive your treatment as prescribed.
2. *The Therapist*, who has scheduled the time for you and your treatment.
3. *Another patient* who could have been scheduled if proper notice was given.

Late Policy (Fifteen Minutes)

We need you to call as soon as you know you are running late. We will begin your scheduled appointments on time. Being late by more than 15 minutes will require you to either reschedule or wait for the next available appointment. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap as this undeservedly compromises the care of another patient.

Other Important Information:

1. **Cell phones must be turned off, or on silent while in our buildings.**
2. Children requiring supervision are NOT allowed to attend sessions with you.
3. Unless you are walking to/from the restroom, you are not allowed in the gym area unless escorted by a member of the ARTTI staff. Please remain in the reception area until a member of our staff is able to escort you.

You will review a more detailed copy of this policy with our Patient Care Coordinator and will receive a copy. This policy is also posted at all reception desks..

Patient's Signature

Legal Guardian's Signature

Date

We look forward to working with you! Your cooperation with our policies is greatly appreciated and will benefit us all.

Achievement Rehabilitation Through Therapeutic Intervention Health Information Privacy Protection Act

WE ARE COMMITTED TO YOUR PRIVACY - Our practice is dedicated to maintaining the privacy of your individual and identifiable information. During the course of your business with us, it will be necessary for us to share aspects of your care and health insurance with specific parties. Federal law prohibits us from doing this without your consent. We are required by law to maintain the confidentiality (of health insurance information that identifies you) from parties other than yourself and your insurance company. We are also required by law to inform you of the parties who may have access to your medical information. This process may include the collection of such information as: your full legal name, home / mailing address, date of birth, social security number, insurance identification numbers, treatment for other related and previous conditions, etc. Please trust that this information will be treated in the safest of manners and will not be shared or disclosed unless as otherwise noted below. This information is never shared with any party outside our facility without your written consent except as noted below and will only be accessed by our staff in order to facilitate your care and or payment for our services.

WE WILL COLLECT INFORMATION FOR MANY PURPOSES - Each time you visit our practice, a record will be maintained of specific information regarding the particulars of that session. This information may include (but is not limited to): medical record maintenance, treatment that was provided, subjective information you provided us regarding your state of being and the state of the condition, assessment information related to the progression of your condition, billing information, communication with insurance companies etc. When communication is made with your insurance company we will maintain a record of these communications either in your medical record or billing record.

HOW MAY WE USE AND DISCLOSE YOUR HEALTH INFORMATION

FOR TREATMENT - We will collect subjective and objective data about you that will be used for your treatment. As part of your care, we may disclose information about your treatment to your referring provider, your insurance company, or anyone else who is directly connected with the treatment of this condition. This information may be provided in verbal and / or written format. It will only be provided in the event that these parties can identify you with three specific criteria.

FOR PAYMENT - We may disclose information about your treatment and services to bill and collect from you, your insurance company or a third party payer related to your insurance company (i.e.: payment management company or a Health Savings Reimbursement Account) or your attorney. This may involve our disclosing information about past and expected future services that have been or will be provided by our facility for this current condition.

FOR HEALTH CARE OPERATIONS AND PERFORMANCE IMPROVEMENT - We may use information in your record to help us improve your care as well as the care of other individuals with similar conditions. This may also include the training of new staff within our facility. In this case, no specific information regarding your identity will be utilized.

INDIVIDUALS INVOLVED IN YOUR CARE - We may disclose information about you to friends and family members who are involved in your medical care or who help to pay for care. In these cases the information released is restricted to those individuals who provide proof of their ability to obtain said information.

I hereby give ARTTI staff permission to release my medical information to the following person/persons and understand this release will remain until the end of my treatment time with ARTTI, unless I specify otherwise. I understand a full version of this notice is available on our website, at <https://achieve-rehab.com/>.

Name

Relationship to You

Patient's Signature

Legal Guardian's Signature

Date

Assignment of Benefits

I, _____ (policyholder name) hereby instruct and direct _____ (insurance company) to pay Achievement Rehabilitation Through Therapeutic Intervention. I assign Achievement Rehabilitation Through Therapeutic Intervention any and all rights, claims, benefits and causes of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services and medical claims resulting from this injury/illness. In the event that I do not have insurance coverage, I understand I remain personally responsible for payment of services including all costs of collection, including attorney's fees and costs.

I authorize release of any medical or other information pertinent to my case to any insurance company, adjuster or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

I understand that I am financially responsible for all charges whether or not they are paid by insurance and that I am responsible for knowing my benefits and insurance coverage.

I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change.

Patient's Signature

Legal Guardian's Signature

Date

Copay/Deductible Collection Policy

Payment is due before services are rendered, unless your insurance requires a percentage copay of services rendered, in which case you must pay before leaving. No exceptions.

We are required by law to collect the copay / coinsurance set by your individual health insurance plan and/or determined by federal guidelines. At no point in time during the patient's course of treatment will the copay and/or deductible amount to be collected from the patient decrease, unless the patient provides us with documentation regarding the change to his/her individual health care plan. In the event that the patient's health insurance provider pays for the full amount of services or pays an amount that is in excess of the patient's copay and/or deductible amount during the patient's prescribed course of treatment, the patient will receive a refund subsequent to the following conditions being met. (1) Completion of the patient's prescribed course of treatment or (2) cessation of treatment services provided by the therapist to the patient and, (3) a formal audit of the patient's balance has been conducted.

Medicare Patients

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the therapy cap (unless your diagnosis is exempt from the cap).

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are: 1) Does your condition interfere with the quality of your life? 2) Does your condition interfere with your ability to perform work or daily activities? 3) Are you motivated and able to participate in your treatment program and follow home and self-care instructions? 4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc? 5) Are there specific goals set that are measurable? If the above criteria are not met, you are welcome to participate in our elective services such as group fitness/exercise training, one on one training performed by a therapist or assistant. These services are payable out-of-pocket by cash, check or credit card.

Patient's Signature

Legal Guardian's Signature

Date



Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Laser therapy can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below

YES NO Do you have a pacemaker or any other implanted device?

YES NO Are you pregnant?

YES NO Do you have cancer?

YES NO Are you taking medication that may increase your sensitivity to light?

YES NO Have you had a steroid injection in the last 7 days?

Patient Signature

Date

Print Patient Name

Notes:

The ultimate decision to recommend treatment lies with your health care provider.
Speak with your health care provider if you have further questions about therapy treatment.



Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. LightForce therapeutic lasers emit infrared light energy into tissue to provide topical heating for the purpose of elevating tissue temperature for temporary relief of minor muscle and joint pain, muscle spasm, pain and stiffness associated with arthritis and promoting relaxation of the muscle tissue and to temporarily increase local blood circulation. Laser therapy utilizes visible and invisible laser radiation; therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment. You may see immediate results after the first treatment, or depending on the severity of your condition, you may require several treatments before beginning to feel results.

Increased soreness may occur after your first laser session. This may be due to changes in circulation to the involved tissues and/ or the impact on different sensory nerves. This is a normal phenomena in the healing process.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

- I understand the above and consent to treatment.

- I understand that failing to complete any part of my treatment program will reduce my chances of success.

Patient Signature

Date

Print Patient Name

Physician Signature

Date