Advanced Therapy

Name____ (Please Print)

I hereby authorize Advanced Therapy, LLC to perform or have performed upon me (or the above name patient) such assessment and treatment procedures as are deemed necessary by Advanced Therapy, LLC. I authorize the release of any information pertinent to my case to any insurance company, attorney, adjuster, or any other person involved in my case. I understand **Advanced Therapy, LLC will charge $20/visit if I do not cancel an appointment within 24 hours.**

Home Addresss____

City__________________________State______________Zip______________

Home phone_______________________Work phone_________________________

Cell phone ____________________________ Date of Birth ___________________

Sex____Employer of the person who carries the health insurance__________________

Emergency contact_______________________________Phone_________________

(If you are on the health insurance policy of your spouse, parent, or friend; please fill out below)

Name of Insured ____

Insured's Address____

City_____________________________State________________Zip_____________

Insured's Birthdate_________________Relationship to Patient ___________________

I understand and agree that (regardless of my insurance staus) I am ultimately responsible for the balance on my account for any professional services rendered by Advanced Therapy, LLC. I certify that I have completed all of the above answers. I certify that this information is true and correct. I understand and agree that should my account be turned over to a collection agency, an additional 10% will be added.

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.

Uses and Disclosure:
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, and providing treatment.

Payment: Your health information may be used to seek payment from you health plan, from other sources of coverage such as 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.

Heath care operations: Your health information may be used as necessary to support the day-to-day activities and management of Advanced Therapy. 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 government-mandated reporting.

Additional Uses of Information: Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

Individual Rights

You have certain rights under the federal privacy standards.

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

Advanced Therapy Duties:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of the privacy practices. We also are required to abide by the privacy policies and practices that are outlines in this notice.

Right to Revise Privacy Practices:
As permitted by law, we reserve the right to 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.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for Advanced Therapy (Effective Date 4/14/03)

Please Sign Name ____________________________________ Date ______________________