ADVANCED THERAPY SERVICES

2648 MAIN ST.
STE B.
CHULA VISTA , CA 91911
619-575-2192
info@ATSoutpatientrehab.com

Dear Patient,

We at Advanced Therapy Services strive to make every patient feel special and our mission is to improve your health and well being in an expedient and professional manner. Please understand that when we schedule your appointment and you cancel without notice and do not show up, you are taking away that very important appointment time from someone else who is also in need of therapy (whether it is for evaluation or follow up treatment). Please be courteous and understanding to other patients attending this clinic.

If you need to cancel or reschedule your appointment for any reason please call our very friendly staff at least 24 hours in advance (619) 575-2192. If you are unable to speak with anyone, please leave a voicemail or send us an email info@ATSoutpatientrehab.com and we will gladly reschedule a more convenient time for you.

We strongly recommend that you reschedule your therapy appointment if at any time you feel sick / ill to prevent other patients and clinic staff from transmittable illnesses. This will enable Advanced Therapy Services to perform and work to our fullest potential in helping patients with their therapy.

Please be advised that if you don't show up for your scheduled appointment or call to reschedule, you will lose your turn in line and may have to wait weeks to be seen again. We ask for your understanding on this policy as we have a long line of patients waiting to be seen.

Thank You,

Administration

Name _____

Date ___/___/_____

Estimado Paciente,

En Advanced Therapy Services nos esforzamos por hacer a cada paciente sentirse especial. Nuestra misión es mejorar su salud y su bienestar de la manera más profesional y conveniente. Le pedimos que por favor comprendan cuando se les ha programado su cita y usted la cancela sin notificación o simplemente no se presenta se le está negando la oportunidad a alguien más de recibir evaluacion o tratamiento.
Por favor le pedimos compresión y cortesía hacia los demás pacientes que assisten a esta clínica. Si es necesario cancelar o reprogramar su cita por cualquier razón, por favor llamar a nuestros amables colaboradores por lo menos 24 horas antes de su cita agendada (619) 575 – 2192. Si no le es posible hablar con un colaborador puede dejar un mensaje en nuestro correo de voz o enviarnos un correo electrónico a info@ATSoutpatientrehab.com y con gusto le reprogramamos otra cita cuando sea más conveniente para usted.

También le recomendamos que reprograme su cita si se siente enfermo/a ya que puede contagiar a otro paciente o algún colaborador. Advanced Therapy Services no podrá realizar su trabajo a su máximo potencial para asistir a otros pacientes con su terapia. Por favor tomen en cuenta que si no vienen a su cita o no llaman para reprogramar su cita perderá su lugar en línea y tendrá que esperar unas semanas para volver a programar su cita. Se le pide su comprensión a nuestra política ya que tenemos muchos pacientes en lista de espera para ser vistos por nuestros terapeutas.

Gracias,

Advanced Therapy Services

Por favor firme si está de acuerdo con nuestros reglamento.

Nombre_____

Fecha _____

AUTHORIZATION AND RELEASE
AUTORIZACIONES Y PERMISOS

Name/Nombre _____

CONSENT FOR TREATMENT
CONSIENTIMIENTO PARA TRATAMIENTO

I, the undersigned, hereby authorize Advanced Therapy Services, Inc. and whomever he/she designates as the assistant(s) to perform diagnostic tests and to administer treatment as is necessary.

I, also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand and agree that health and accident reports and forms to assist me in making collection from the insurance company and the amount authorized to be paid directly to this office with be credited to my account upon receipt. I permit this office to endorse remittances for the credit to my account.

Yo, autorizo a Advanced Therapy Services y otras personas autorizadas o asignadas como asistente(s) para praticar analisis diagnosticos, y para administrar tratamiento necesario.

Yo, tambien, certifico que no se me da garantia alguna que el tratamiento subministrado sera completamente effectivo.

Yo comprendo y estoy de acuerdo que el contrato de polizas de seguro medico y accidente son responsabilidad entre la compania de aseguranza y de la suma autorizada pagable directamente a esta oficina el cual sera acreditado a mi cuenta a ser recibido.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
AUTORIZACION PARA DAR INFORMACION MEDICA

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Yo autorizo de dar cualquier informacion medica necesaria para procesar mi(s) caso(s) de aseguranza y tambien certifico que toda la informacion de aseguranza dada a esta clinica es correcta y completa.

REQUEST FOR PAYMENT OF BENEFITS TO PROVDIER OF CARE
AUTORIZACION PARA PAGO DE BENEFICIOS A PROBEDOR DE SALUD

I hereby authorize _____ Insurance Company/Insurance Administrator to pay by check and mailed directly to Advanced Therapy Services, Inc. the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay in a current manner any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Yo autorizo a _____ la Compania de Aseguranza/Administrador de Azeguranza que pague con cheque y enviar por correo a Advanced Therapy Services, Inc. los beneficios y/o pagable directamente a mi bajo mi polizas presente, con pago a la cantidad total por los servicios profesionales dado estoy de acuerdo en pagar cualquier cantidad restante por los cargos indicados en una manera pronta. Yo, tambien estoy de acuerdo en delegar carta poder a esta oficina para endorsar/firmar mi nombre en cualquier y toda formas de pago de mi cuenta.

Patient's Signature_____ Date___/___/_____
Firma de Paciente Fecha

INTRODUCTION
INTRODUCCION

Sex(Sexo) ☐ F ☐ M

Name _____
Nombre

Address _____ City _____ State _____ Zip _____
Domicilio Ciudad Estado Codigo Postal

Home Phone _____ Birth date _____ Occupation _____ Work Phone _____
Telefono de la Casa Fecha de Nacimiento Ocupacion Telefono de Tabajo

Work Address _____ City _____ State _____ Zip _____
Domicilio de Trabajo Ciudad Estado Codio Postal

Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced
(Estado civil) (Casado) (Separado) (Soltero) (Viudo) (Divorciado)

Social Security Number _____ Ethnicity _____ Religion _____
Numero De Seguro Social Etnia Religion

Emergency Contact _____ Phone _____
Persona a Contactar en caso de Emergencia Su Telefono

INSURANCE INFORMATION
INFORMACION DE LA ASEGURANZA

Relationship to Insured _____
Relacion con el Asegurado

Insured's Name _____ Birth Date _____
Nombre Del Asegurado Fecha De Nacimiento

Address _____ City _____ State _____ Zip _____
Domicilio Ciudad Estado Codigo Postal

Insurance Company _____ Group# _____ ID# _____
Compania de Aseguranza Grupo Numero Grupo Numero

Additional Insurance Co. _____ Group# _____ ID# _____
Compania Adicional Aseguradora Grupo Numero Grupo Numero

MEDICAL PROBLEMS
PROBLEMAS MEDICOS

Describe your Symptoms _____
Describa sus Sintomas

Date Symptoms Started _____ Date Symptoms Became Worse _____
Cuando Empezaron Sus sintomas Cuando Fueron Mas Molestos Sus Sintomas

Doctors You Have Visited _____
Que Medicos a Visto

Are You taking Medications? _____
Esta Usted Tomando Medicamentos?

Medications you are taking _____
Que Clase de Medicamentos Esta Usted Tomando

Referring Physician _____ UPIN# _____
Doctor que le Referio

History and Physical Condition Information
Informacion de Historia Fisica

Primary Care Physician: _____ Phone: _____
Medico de Cabecera Su Telefono

Do you have or have you had any of the following?Tiene usted o a tenido lo siguiente?

	yes(si)	no		yes(si)	no
High Blood Pressure Alta Presion	☐	☐	Sensitive to heat/ice Sensibilidad al calor o al frio	☐	☐
Heart Disease Enfermedad del Corazon	☐	☐	Allergies Alergias	☐	☐
Heart Attack Ataque del Corazon	☐	☐	Hernias Hernias	☐	☐
Pace Maker Marcapaso	☐	☐	Seizures Convulsiones	☐	☐
Diabetes Diabetes	☐	☐	Metal Implants Implantes de metal	☐	☐
Headaches Dolores de cabeza	☐	☐	Dizzy Spells Mareos	☐	☐
Kidney problems Problemas del rinon	☐	☐	Balance Problems Problemas de estabilidad (balance)	☐	☐
Nervous disorder Desorden nervioso	☐	☐	Vision Problems Problemas de vision	☐	☐
Hearing Problems Sordera	☐	☐	Allergies to medication Alergias a medicamento	☐	☐

If yes on any of the above, please explain and give approximate dates:
Si contesto si alguna de las preguntas, por favor explique y de la fecha aproximada:

Have you had surgery associated with your current injury /diagnosis for which you were referred?Tuvo cirugia asociada con su diagnostico presente por el cual usted fue referido? ☐ yes(si) ☐ no

If yes please list date and type of surgery:
Si afirmo , por favor de la fecha y tipo de cirugia:

Please list activities that are limited because of your injury/diagnosis:
Por favor describa que limitaciones de actividades tiene usted relacionadas con su diagnostico(problemas):

Have you ever had physical therapy before? ☐ yes(si) ☐ no
A tenido usted terapia fisica anteriormente?

Signature: _____ Date: ___/___/_____
Firma Fecha

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspodence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message will call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message will call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed property, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

1)Check this box if the disclosure is authorized
2)Type key: **T**=Treatment records; **P**=Payment Information; **O**=Healthcare Operations
3)Enter how disclosure was made: **F**=Fax**:P**=Phone: **E**=Email : **M**=Mail : **O**=Other

Important message from management:

Please be reminded that you are in a private facility. Be considerate to everyone.

- •Turn phones to vibrate
- •No playing of music or videos (unless using earphones)
- •Please take phone conversations outside.

We appreciate your cooperation and understanding.

I agree with the terms (initials) _____ **Date** _____

Mensaje importante de administracion:

Porfavor de recordar que usted esta en una clinica privada. Sea considerado con todos porfavor.

- • Coloque el telefono en vibrador
- •No musica o videos (solo con audifonos)
- •Tomar llamadas afuera de la clinica

Apreciamos su cooperacion y entendimiento. **Yo**

estoy de acuerdo con las condiciones (iniciales) _____ **Fecha** _____

When the application is filled out and completed there are a few options on how to proceed. Please pick one from the options below:

1. Please print all the pages, sign & initial necessary pages and bring them with you at the time of your appointment.
2. Please print all the pages, sign & initial necessary pages and fax your application to (619) 575-0053.
3. Please print all the pages, sign & initial necessary pages scan or take a picture of all the pages and Email to info@ATSoutpatientrehab.com

CLEAR PRINT