



Advanced Therapy Concepts Home Equipment Order Form

*Please fax this form **with Patient Demographics/Insurance Information** to:
(616)772-9368 or Email **info@advancedtherapyconcepts.com**

Therapist / Contact Name

Phone: _____

Clinic: _____

Fax: _____

ComfortWave (IFC/NMES)



Pneumatic Cervical Traction



U-Stim or J-Wave (NMES)



Horizon 637 LSO

Patient Measurement (Waist) -
Inches: _____



J-Stim (Hi-Volt) w/ Garments

Garments (Circle One):

Sock / Sleeve

Glove / Sleeve



Electrodes Only

Garments (Circle One):

LUMBAR

THORACIC

KNEE

CERVICAL

SHOULDER

ANKLE

Other Available Products

(Circle One):

DDS 500 LUMBAR TRACTION BELT

PNEUMATIC LUMBAR TRACTION

Patient Name:

DOB:

ICD 10 Dx Codes:

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

NPI: _____

Physician's Signature (Optional): _____ Date: _____

Please call 800-864-0293 with any Questions! We truly appreciate all of your help and support!