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**

_____ **Clinic:** _____

Therapist / Contact Name

Phone: _____ **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 CERVICAL

THORACIC SHOULDER

KNEE 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!