***PLEASE COMPLETE FRONT AND BACK OF ALL FORMS**

Date: _____

Last Name_____ First Name_____ MI_____

Street Address_____

City_____ State_____ Zip_____ Ailment_____

Telephone: Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

***E-mail_____

Would you like to receive appointment reminders by E-mail? Y / N

Date of Birth_____/_____/_____ Social Security # _____/_____/_____

Emergency Contact _____ Phone (_____) _____-_____

Referring Physician _____ PCP _____

How did you hear about us? ( ) Website ( ) Google ( ) Insurance Co. ( ) Doctor ( ) Yelp

( ) Twitter ( ) Previous Patient ( ) Friend/Family_____

Appointment time needed _____ Flexible schedule? Y / N

Primary Insurance Information

Who is the Insured? Self ( ) Spouse ( ) Parent ( ) Other ( )

Last Name_____ First Name_____ MI_____

Telephone: Home (_____) _____-_____ Cell (_____) _____-_____ Date of Birth_____/_____/_____

Social Security # _____/_____/_____ Name of Ins. Co. _____

ID # _____ Group # _____

Secondary Insurance Information

Who is the Insured? Self ( ) Spouse ( ) Parent ( ) Other ( )

Last Name_____ First Name_____ MI_____

Telephone: Home (_____) _____-_____ Cell (_____) _____-_____ Date of Birth_____/_____/_____

Social Security # _____/_____/_____ Name of Ins. Co. _____

ID # _____ Group # _____

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for healthcare services or supplies may be made directly to Superior Physical Therapy. I also acknowledge that by signing below, I hereby accept the terms and agreements made by the Patient Registration Form.

_____ _____ _____

Signature of Responsible Party Relationship to Patient Date

Superior Physical Therapy & Sports Rehab
www.Frederickpt.com

65D Thomas Johnson Drive
Frederick, MD 21702
301-663-7898

9093 Ridgefield Drive, Suite 201
Frederick, MD 21701
301-696-5595

Consent for Medical Treatment Policy

1. **Consent for Health Care Services**: I authorize consent for medical treatment at Superior Physical Therapy.

2. **Authorization for Release of Information**: Superior Physical Therapy may release information from my medical records to any health care provider involved in my care and treatment. Superior Physical Therapy may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Superior Physical Therapy is no longer responsible for the confidentiality of any information known or possessed by the payer.

3. **Financial Agreement**: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Superior Physical Therapy ***which are not paid*** by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Superior Physical Therapy, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Superior Physical Therapy. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.

4. **Workers Compensation, Auto Claims, and Other Legal Cases:** I understand that on or before the initial visit, accurate and current information is to be given to Superior Physical Therapy to file the insurance claim. Superior Physical Therapy will also make copies of my personal health insurance card(s). My personal insurance information will be kept on file for 10 months; at the end of 10 months if no progress is being made in my legal case Superior Physical Therapy will file these claims to my personal health insurance. I understand that I will be responsible for any deductibles, copayments or co-insurance.

5. **Preauthorization Requirements**: I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Superior Physical Therapy charges. I understand that if the required referral or pre-authorization is not obtained, I am responsible for full payment for all services rendered.

6. **Assignment for Direct Payment**: I authorize that payment of any insurance benefits (including health insurance, auto insurance and workers' compensation) for healthcare services or goods to be paid directly to Superior Physical Therapy.

7. **Charge for No Show / Cancellation without 24-hour notice**: I understand that 24-hour notice is required for canceling an appointment and that a $25.00 cancelation fee may be billed to me for failure to provide 24-hour notice. I understand that I will be charged a $50.00 fee for any No Show appointment. I also understand that I will be financially responsible for these charges, as they are not covered by any health insurance.

8. **Rescheduling Appointments**: I understand it is my responsibility to contact Superior Physical Therapy in the event I need to change any scheduled appointments.

2018
Consent for Medical Treatment

I acknowledge that:

- I have read the Consent for Medical Treatment form and understand its contents.
- I am the patient or person duly authorized, either by the patient or otherwise, to sign this agreement, to consent to and to accept its terms.
- I am responsible for payment of all co-payments at the time of service and for full payment of any balance due within 30 days of receiving a billing statement.
- I have received a copy of Superior Physical Therapy's Consent for Medical Treatment Policy.
- All information that I have provided to Superior Physical Therapy is true, accurate and completed to the best of my knowledge.

_____	_____
Signature of Patient/Responsible Party	Date
_____	_____
Patient/Responsible Party's Printed Name	Relationship to Patient

Insurance Waiver

I understand that if Superior Physical Therapy is not an in-network participating provider for my insurance company, I agree to pay all charges and will submit on my own for reimbursement of any charges from my insurance company.

_____	_____
Signature of Patient/Responsible Party	Date
_____	_____
Patient/Responsible Party's Printed Name	Relationship to Patient

Please, take your time filling out this form. It is imperative that we have accurate information to be able to complete a thorough assessment and help us pursue the best course of action

Last Name _____ First Name _____ Date of Birth _____/_____/_____
Height: _____ Weight: _____

Currently I am experiencing (circle all that apply):		
Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss/gain
Numbness/Tingling	Changes in appetite	Difficulty swallowing
Depression	Shortness of breath	Dizziness
Headaches	Malaise	Abnormal Heart Rate
Night Sweats/Pain	Nausea/Vomiting	Lightheadedness
Chest Pain	Swelling	double vision

Was this an automobile accident? Y or N If yes, date: _____

Was this a work related accident? Y or N If yes, date: _____

- Any time off work? Y or N If yes, dates: _____

Have you had any surgery(s)? Y or N If so, list with dates

_____
_____
_____
_____

Medication List: please bring a current list of medications that includes dosage, frequency, route (orally, IV, drops…). If not please fill out medication list page.

High Blood Pressure		Fainting		Liver Disease	
Heart Disease or Heart Attack		Anxiety/Panic Attacks		Traumatic Brain Injury	
High Cholesterol		Arthritis		Thyroid Problems	
Asthma		Hepatitis		Bowel/Bladder Incontinence	
Allergies		Kidney Disease/Stones		Abdominal Pain	
Bronchitis		Spinal Cord Injury		Polio/Muscle Disease	
Blood Disorders		Ulcers		Migraines/Headaches	
Emphysema		Seizures		Sleep Disorders	
Anemia		TMJ Disorder		Lyme Disease	
Diabetes		Blood in Stool		Chronic Fatigue (Syndrome)	
Hypoglycemia		Depression		Fibromyalgia	
Concussion		Cancer		Gynecological Disorders	
Fractures		Sexually Transmitted Disease		Osteoporosis	

Please answer the following questions:

1. Are you a smoker? Y or N If so, how long? _____ How many packs/day? _____
2. Do you drink? Y or N If so, how many drinks/wk? _____
3. Are you Pregnant? Y or N If so, what is your due date? _____
4. Are taking a blood thinner? Y or N
5. Do you have a pacemaker or any other medical transplant equipment? Y or N
6. If you answered "yes" to Cancer please list type(s): _____
7. If you answered "yes" to fractures, please list type and date: _____
8. If you answered "yes" to arthritis please list type(s): _____
9. Please list any pertinent family medical history: _____
10. If you are a female athlete: do you skip any meals during the day or secretly eat meals? _____
    a. Are you having any irregular or absent menstrual cycles? _____
    b. Have you noticed any wide fluctuations of weight? _____
11. Have noticed any of the following (circle): discoloration of urine, change of frequency, urgency, incontinence

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

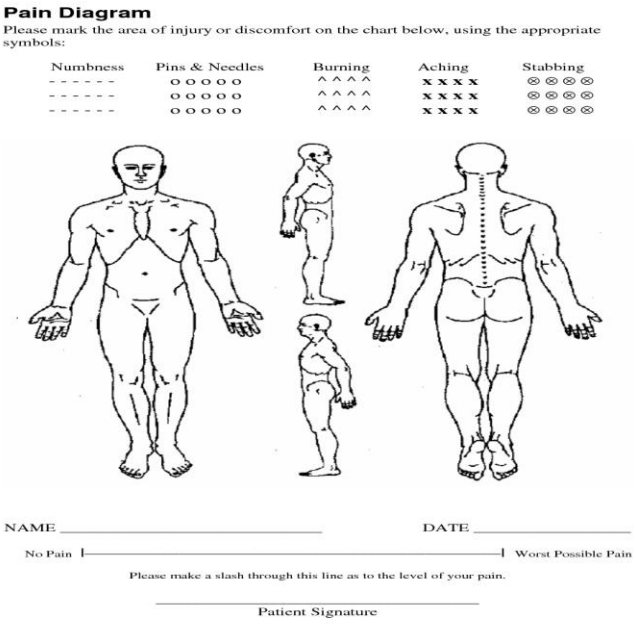
Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

This Section is meant to help us assess your current condition:

- Please tell me where you feel your current pain/symptoms? _____
- About when did you pain/symptoms start? _____
  - Did your pain come on (circle one): **suddenly** or **gradually**
  - Was there an injury/trauma? Y or N If yes, what? _____
  - Are your symptoms (circle one): **getting better** or **getting worse** or **about the same**
- Have you received any treatment for this problem in the past? _____
  - If so, what treatment and did it help? _____
- Are you experience any (please circle): extreme fatigue, wt. loss, change in bowel/bladder function
- Did you have a recent surgery? Y or N. If yes, what kind? _____
  - Do you have swelling? Y or N. If so, where? _____
  - Does the area feel warm or is it red? Y or N Do you have point tenderness? Y or N
  - Do you have pain? Y or N. If yes please fill out on pain diagram below.

Please identify where your pain and symptoms are located. Please use a (?) if pain is different from the ones listed below



Please rate you pain on a scale of 0 – 10 (0 being no pain and 10 being worse pain you could ever imagine)

• Currently:	1	2	3	4	5	6	7	8	9	10
• Average over 72 hours:	1	2	3	4	5	6	7	8	9	10
• Worse over 72 hours:	1	2	3	4	5	6	7	8	9	10
• Best over 72 hours:	1	2	3	4	5	6	7	8	9	10

- What makes your symptoms/pain worse:
  _____
- What makes your pain symptoms better:
  _____

Please tell me what your personal goal is with therapy?
_____

I have answered the above questions to the best of my ability. I understand that this information will only be used in my health care operations to help provide me with the most accurate and best care.

Patient Signature: _____ Date: _____

Medication List (if you don't have a copy of your current medications, dosage, frequency, and route, this form will help you maintain an accurate list for future medical needs). If you have a list, just write "see list" under medication and fill out rest of form.

Medication	Dosage	Frequency	Route	Reason

Have you had any recent changes in your medication dosage, frequency, or type? Yes or No

- **If yes, please describe changes: _____**

Do you feel that your medication is contributing to any falls, dizziness, or other symptoms you are experiencing? Yes of No

- **If yes, please explain: _____**

Have you ever been on long term use of corticosteroids? Y or N

- **If yes, when, and for how long? _____**

Have you or, are you taking any performance enhancing drugs? Y or N

- **If yes, what are you taking? _____**

The above list of medications is accurate to the best of my knowledge!

Patient Signature: _____ Date: _____

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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date: January 2, 2015.

To obtain more information about your privacy rights or our privacy policies, you may contact our Privacy Officer.

Earl Cox
Superior Physical Therapy & Sports Rehab
65D Thomas Johnson Dr
Frederick, MD 21702
earl@frederickpt.com
(301) 663-7898

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES UNDER HIPAA GUIDELINES

Please sign your name and print your name and date on this acknowledgement form, then detach the form from the Notice and return your signed acknowledgement to the receptionist.

Printed Name: _____

Signature: _____ Date: _____

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Name: _____ Date of Birth: _____/_____/_____

Release of Information

[ ] I authorize the release of information including diagnosis, treatment and financial information to the following people:

_____ _____

_____ _____

_____ _____

[ ] This information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please contact me at: [ ] Home [ ] Work [ ] Cell [ ] Email

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] _____

The best time of day to reach me is between _____ am/pm and _____ am/pm.

Signed: _____ Date: _____/_____/_____

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To All Patients:

We are not required to issue each patient his or her own set of electrodes for electrical stimulation treatment performed in the clinic. However, you have the option to purchase your own electrodes for personal/hygiene reasons. There will be a one-time fee of $10.00 payable upon your first treatment. This is not covered by health insurance.

In the event the physical therapist deems it necessary for you to obtain your own electrodes for medical conditions such as an open wound or skin rash, you will also be responsible for this one-time fee of $10.00.

If you choose not to purchase your own electrodes, you will be using community electrodes which will be disinfected and also used by other patients.

Thank you.

☐ I wish to purchase my own electrodes.

_____ _____
Signature of Patient/Responsible Party Date

☐ I DO NOT wish to purchase my own electrodes.

_____ _____
Signature of Patient/Responsible Party Date

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AS OF JANUARY 1, 2006
MEDICARE HAS REINSTATED THE CAP ON THERAPY SERVICES

Medicare has a cap of $2,010.00 per calendar year for combined Physical, Occupational, and Speech Therapies (As of 1/1/16)

Superior Physical Therapy will try to assist you in monitoring your Medicare therapy benefits. When you receive an explanation of benefits from Medicare, it will contain a section to inform you of your therapy benefits for the year. When your benefits are **approaching $2,010.00**, you should notify us so that we can assist you in your decision to continue therapy. For most diagnoses, Medicare will deem treatment medically necessary and will **cover up to $3,700**.

If you should need treatment after you have reached your cap limit for this year, you may continue to be treated in our office and will have to pay for services out of pocket or through a secondary insurance. Please review the benefit summary of notice given to you by our office to verify if your secondary insurance covers services beyond the Medicare cap. Services received in the inpatient department of a hospital are not subject to the therapy cap, so you may continue your treatment at such a facility.

You may also be eligible for full ongoing benefits according to your diagnosis. Please discuss this with your Practitioner.

I have read and I am aware of the Medicare therapy cap described above.

_____ _____

Signature of Medicare Beneficiary Date