PATIENT AUTHORIZATION

Patient Name:

Release of Information

All information provided herein is true and correct.

I hereby consent to treatment.

I give permission for Physical Therapy & Pain Management Center, LLC. To release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize Physical Therapy & Pain Management Center, LLC. To obtain medical records and/or professional information from my physician and other medical professionals as it relates to my treatment.

Information without patient identifiers may be used for quality assurance purposes.

Assignment of Benefits

I authorize payment directly to Physical Therapy & Pain Management Center, LLC.

This is a direct assignment of my rights and benefits under this policy.

A Photocopy of this assignment shall be considered as effective and valid as the original.

Notice of Privacy Practices (HIPPA Acknowledgment/ Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Physical Therapy & Pain Management Center, LLC.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Payment Guarantee

I agree to pay Physical Therapy & Pain Management, LLC. For the services and/or products provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services and/or products I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

I acknowledge that the benefit verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, or that coverage is insufficient, I will be responsible for payment of any unpaid portion of payment for any and all services and/or products received from Physical Therapy & Pain Management Center, LLC.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in written by myself and a representative of Physical Therapy & Pain Management Center, LLC.

I have read the above and understand the information provided. I authorize treatment and the release of information as explained. I approve of the Assignment of Benefits, acknowledge I have received the HIPPA Notice of Privacy Practices and guarantee payment.

Patient or Guardian Signature: Date:

PAST MEDICAL HISTORY
PHYSICAL THERAPY & PAIN MANAGEMENT CENTER, LLC.

Patient Name: _____ Date of Birth: _____

Reason for therapy: _____ Date of Injury/Onset: _____
Have you previously received therapy for this condition? □ yes □ no If so, when? _____
Previous treatment received? _____

For our female patients: Could you be or are you pregnant? □ yes □ no
Do you now or have you ever had any of the following medical conditions:

Arthritis	□yes □no	Hepatitis	□yes □no
Asthma	□yes □no	Hernia	□yes □no
Anemia	□yes □no	High Blood Pressure	□yes □no
Anxiety	□yes □no	Infections	□yes □no
Bladder Problems	□yes □no	Kidney Problems	□yes □no
Chronic Cough	□yes □no	Metal In Body	□yes □no
Cancer	□yes □no	Osteoporosis	□yes □no
Clotting/DVT	□yes □no	Osteopenia	□yes □no
Diabetes	□yes □no	Pacemaker	□yes □no
Depression	□yes □no	Respiratory Problems	□yes □no
Dizziness	□yes □no	Seizures	□yes □no
Epilepsy	□yes □no	Sensitivity to Cold/Hot	□yes □no
Fainting Spells	□yes □no	Shortness Of Breath	□yes □no
Fractures	□yes □no	Stroke	□yes □no
Gout	□yes □no	Surgeries	□yes □no
Headaches	□yes □no	Swelling	□yes □no
Head Injury	□yes □no	Thyroid Problems	□yes □no
Hearing Loss	□yes □no	Tuberculosis	□yes □no
Heart Attack	□yes □no	Vascular Disease	□yes □no
Heart Disease	□yes □no	Weight Loss/Gain	□yes □no
HIV/AIDS	□yes □no	Other: _____	

If you answered "yes" to any of the above, please explain and give approx dates and treatment:

_____

_____

_____

_____

Allergies? □ yes □ no If yes, list allergies: _____

Are you presently taking any medications? □ no □yes, list medications and specify condition:

This information is correct and complete to the best of my knowledge.

X_____ **Date:** _____
Patient/ Parent/ Guardian Signature

Standard Authorization of Use and Disclosure of Protected Medical Information

Information to be Used or Disclosed
Information covered by this authorization includes:
Physical Therapy Medical Records, Prescriptions, Referrals, Medical Reports

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:
Physical Therapy & Pain Management Center, LLC.

Name of Person/Organization

Persons to Whom Information May be Disclosed
Information described above may be disclosed to:
Referring Physician, Primary Care Physician, Health Insurance Carrier

Name of Person/ Organization

Name of Person/ Organization

Expiration Date of Authorization: This authorization remains in effect until canceled or revoked in writing by the patient or the patient's authorized personal representative.

Right to Terminate or Revoke Authorization
You may terminate or revoke this authorization by submitting a written request to do so signed by you or your authorized personal representative (with copy of appropriate power of attorney) to *Physical Therapy & Pain Management Center, LLC. (11120 New Hampshire Ave., Ste 200, Silver Spring, MD, 20904)*

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of information sent under this authorization may not be protected under the federal privacy regulations.

Signature

Name of Patient (Print or Type)

Signature of Patient Date

Signature of Patient Representative Date

Relationship of Patient Representative to Patient

Dear Patient:

It is the expectation at the time any appointment for physical therapy is made that you have all good intentions of keeping that appointment. It is also the expectation that your physical therapy staff will do all within their power to accommodate any special scheduling needs such as specific times of the day due to work or special events. By the same token, we need you to understand from the time of the original evaluation that success towards achievement of any of your rehabilitation goals requires your attendance and diligent efforts. Failure to attend scheduled appointments creates the risk of not fulfilling those goals, and may impact on other patients who may not be able to get scheduled a particular day because there may be no open appointments. It is recognized by management that on occasion, patients may need to cancel, but it is hoped that this is a rare event, and not a repeated one.

For the benefit of all our patients who need to have their appointments at specific times we have instituted a cancellation fee for those who have repeatedly canceled or failed to show for appointments without notifying this office at least **24 hours in advance.** The Clinical Director may therefore charge a cancellation fee of $20.00 and a no show fee of $40.00 for failure to notify us of your inability to attend with such proper notice. Excessive missed appointments may constitute a discharge of your care. Please exercise diligence and respect the time of your therapists.

Only the Clinical Director has the authority to waive cancellation fees based on extraordinary circumstances, and a copy of our cancellation policy is available at the facility.

Thank you for understanding our desire to have all patients be scheduled at the times they require and for expecting our patients our patients who do have a conflict to provide adequate notice.

Sincerely,

Clinical Director

Patient signature is an acknowledgment of cancellation policy.

Signature of patient _____ Date_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Physical Therapy & Pain Management Center, LLC to release a copy of my medical records to _____.

_____

Patient or Guardian Signature **Date**

Please include the following items:

_____
_____
_____
_____
_____
_____
_____

Confidentiality Note: The documents accompanying this facsimile transmission may contain confidential information. The information is intended only for the use of the individual or entity names above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the information contained in this transmission in error, please notify the sender immediately by telephone or by return FAX and destroy this transmission, along with any attachments. Thank you.