

**White Oak Physical Therapy  
& Pain Management Center  
11120 New Hampshire Avenue  
Suite 506  
Silver Spring, MD 20901**

**David Bullock, PT  
Chinh Le, PT**

**Phone: 301-592-8200  
Fax: 301-592-8300**

**AUTHORIAZION FOR RELEASE OF MEDICAL RECORDS**

**I hereby authorize White Oak Physical Therapy & Pain Management Center to  
release a copy of my medical records to \_\_\_\_\_.**

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**Patient or Guardian Signature**

**Date**

**Please include the following items:**

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**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 named 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.**

# 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*

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## Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

*White Oak Physical Therapy & Pain Management Center*

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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*

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Name of Person/Organization

Name of Person/Organization

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**Expiration Date of Authorization: this authorization remains in effect until cancelled 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 *White Oak Physical Therapy & Pain Management Center*

*(11120 New Hampshire Ave., Ste 506, Silver Spring, MD, 20904).*

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## 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)

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Signature of Patient

Date

Signature of Patient Representative

Date

Relationship of Patient Representative to Patient

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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 of our patients who need to have their appointments at specific times we have instituted a cancellation fee for those who have repeatedly cancelled 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 who do have a conflict to provide adequate notice.

Sincerely,

Clinical Director

Patient signature is an acknowledgement of cancellation policy.

Signature of patient \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT AUTHORIZATION

**Patient Name:**

### Release of Information

All information provided herein is true and correct.

I hereby consent to treatment.

I give permission for White Oak Physical Therapy & Pain Management Center 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 healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize White Oak Physical Therapy & Pain Management Center 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 White Oak Physical Therapy & Pain Management Center.

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 (HIPAA Acknowledgement / Consent)

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

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 White Oak Physical Therapy & Pain Management Center 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 White Oak Physical Therapy & Pain Management Center.

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 writing by myself and a representative of White Oak Physical Therapy & Pain Management Center.

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**  
**WHITE OAK PHYSICAL THERAPY & PAIN MANAGEMENT CENTER, LLP**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for therapy: _____	Date of Injury/Onset: _____
Have you previously received therapy for this condition? <input type="checkbox"/> yes <input type="checkbox"/> 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	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Hepatitis	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Asthma	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Hernia	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Anemia	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		High Blood Pressure	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Anxiety	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Infections	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Bladder Problems	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Kidney Problems	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Chronic Cough	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Metal in body	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Cancer	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Osteoporosis	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Clotting /DVT	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Osteopenia	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Diabetes	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Pacemaker	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Depression	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Respiratory Problems	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Dizziness	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Seizures	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Epilepsy	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Sensitivity to cold/hot	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Fainting Spells	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Shortness of Breath	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Fractures	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Stroke	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Gout	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Surgeries	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Headaches	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Swelling	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Head Injury	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Thyroid Problems	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Hearing Loss	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Tuberculosis	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Heart Attack	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Vascular Disease	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Heart Disease	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Weight Loss /Gain	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
HIV/AIDS	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		Other				

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies?  no  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	

**Patient Name:** \_\_\_\_\_ **M F** **Marital Status:** S M D W  
**Address:** \_\_\_\_\_  
Street City / State Zip  
**Phone: (Home)** \_\_\_\_\_ **(Cell)** \_\_\_\_\_  
**SS#:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Driver's License:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **(Work Phone)** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Employer Address:** \_\_\_\_\_  
Street City / State Zip  
**Emergency Contact:** \_\_\_\_\_ **Emergency Phone:** \_\_\_\_\_  
**Referring MD:** \_\_\_\_\_ **Primary Physician:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_ **Injury/Onset Date:** \_\_\_\_\_  
**How did you learn about us:** **Physician** **Medical Directory** **Yellow Pages** **Internet**  
**Former Patient** **Postcard** **Sponsored Event**

**Insurance Policy Holder:** Self / Other: \_\_\_\_\_ **Insured DOB** \_\_\_\_\_  
**Relationship to patient:** Spouse / Parent / Other: \_\_\_\_\_ **Insured SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Insured's Employer:** \_\_\_\_\_

**Primary:**  Automobile (PIP)  Workman's Compensation  Medicare  Commercial Insurance  
**Insurance Name:** \_\_\_\_\_ **ID / Claim #** \_\_\_\_\_ **Group** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Extension:** \_\_\_\_\_ **Adjuster:** \_\_\_\_\_  
 \*\*\*\*\*  
**Secondary:**  Automobile (PIP)  Workman's Compensation  Medicare  Commercial Insurance  
**Insurance Name:** \_\_\_\_\_ **ID / Claim #** \_\_\_\_\_ **Group** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Extension:** \_\_\_\_\_ **Adjuster:** \_\_\_\_\_

I have reviewed the above information, other than any changes indicated above, I found the information to be correct. I have been informed of the above coverage verified and understand that this is only a verbal verification of benefits, NOT a guarantee of payment by my insurance company. This is NOT a guarantee of payment. We encourage you to independently verify you own insurance.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_