

**Cardin & Miller Physical Therapy**

(Please Print)

**PATIENT INFORMATION**

Patient Name:		Date of Birth:	Social Security #:	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parents Name (if under 18):			Contact Phone #:	
			Contact Phone #:	
Street Address:		City:	State & Zip:	
Home Phone #:	Work Phone #:		Cell Phone #:	
Email Address:				
Occupation:		Employer:		
Have you had Physical, Occupational, Speech, Chiropractic or Home Therapy this year?	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	When/Where:	
Referring Physician:		City:	Phone #:	
Primary Care Physician:		City:	Phone #:	

**INSURANCE INFORMATION**

(Please give your insurance card and photo identification to the receptionist.)

Is this a workman's compensation or auto claim?	<input type="checkbox"/> YES	Claim #	Adjusters Name:	
	<input type="checkbox"/> NO	Name of Company:	Adjusters Phone #:	
Is this patient covered by insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<b>Primary Insurance Name:</b>		Identification #:		
		Group #		
Subscribers Name:		Subscribers Date of Birth:		
<b>Secondary Insurance Name:</b>		Identification #:		
		Group #		
Subscribers Name: Same As Above <input type="checkbox"/>		Subscribers Date of Birth:		
<b>Tertiary Insurance Name:</b>		Identification #:		
		Group #		
Subscribers Name: Same As Above <input type="checkbox"/>		Subscribers Date of Birth:		

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone #:	Work Phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Cardin & Miller Physical Therapy. I understand that I am financially responsible for any balance for non-covered services. I also authorize Cardin & Miller Physical Therapy to release any information required to process my claims and to bill my insurance company on my behalf for services rendered.

		<b>DATE OF REVISION</b>	
Signature of Patient	Date		
Signature of Parent (if under 18), Legal Guardian or POA	Date		

**PHYSICAL THERAPY AND DURABLE MEDICAL HEALTH HISTORY FORM**

Patient Name:	Age:	Date:
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Reason for Today's Appointment:	Date of Injury (if applicable):
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<b>Have you had any of the following for this problem:</b>	<input type="checkbox"/> MRI <input type="checkbox"/> X-Ray <input type="checkbox"/> CT Scan	Where:
	<input type="checkbox"/> Other	When:

<b>Have you had surgery for this problem:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	Where:
Name of Surgeon:	When:	

<b>Do you smoke:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Is it possible that you are pregnant?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**Please list any medications you are taking:**


**Have you had or do you have any of the following conditions:**

Heart Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Fractures	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Bleeding Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	Strokes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other:	
Chronic Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Dizzy Spells	<input type="checkbox"/> No <input type="checkbox"/> Yes	Emphysema	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Fainting Spells	<input type="checkbox"/> No <input type="checkbox"/> Yes	Back Injury	<input type="checkbox"/> No <input type="checkbox"/> Yes		

<b>Do you have any pain?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Do you have numbness or tingling?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
Where?	Where?
Type: <input type="checkbox"/> Sharp <input type="checkbox"/> Ache <input type="checkbox"/> Burning	<b>Do you have swelling?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Other	Where?

**Please rate your pain on a scale of 0-10. 0 being no pain or discomfort and 10 indicates extreme pain and extreme discomfort. (indicate by circling the appropriate number)**

0   1   2   3   4   5   6   7   8   9   10	0   1   2   3   4   5   6   7   8   9   10
(pain at its least)	(pain at its worst)

**ATTESTATION**

The above information is true to the best of my knowledge.

		<b>Date of Revision</b>	
Signature of Patient	Date		
Signature of Parent (if under 18), Legal Guardian or POA	Date		

**Financial Policy and Protected Health Information Acknowledgement and Consent**

***Financial Policy***

Cardin & Miller Physical Therapy charges what is usual and customary for your therapy treatment sessions and products. Your insurance is a contract between you and your insurance company and we encourage you to know your insurance coverage. We do accept assignment from many insurance companies and we are contracted with those insurance companies to process the claims as directed. It is your responsibility to verify our participation with your insurance. In the event that we do not accept assignment of benefits, you will be responsible for payment. Your insurance company has final determination of payment and you will be billed for any and all copays, coinsurances, deductibles and all member/patient liabilities. All copays are due and payable at the time of service. Please remember that Cardin & Miller Physical Therapy will verify your benefits but this is never a guarantee of payment and benefits quoted are based on information given on the date of service. It is your responsibility to update your insurance with our practice as it changes. Cardin & Miller can not be held responsible for any changes in insurance information after services are rendered. We do follow regular practice guidelines for the billing of your account. If for any reason your account should become delinquent past 90 days or no current address is on file, we will use Berks Credit & Collections to collect on your account. If your account should be placed with Berks Credit & Collections, any and all correspondence and payments will be made directly to them.

***Protected Health Information***

Cardin & Miller Physical Therapy has a notice of privacy practice that describes how we may manage, use and disclose your protected health information. This form also describes how we may access your information and exercise our rights in using this information while you are a patient in our practice. We will exercise our right to use and disclose health information about you for treatment, payment and health care operation purposes. We do follow the legal guidelines in our practice where your protected health information is concerned. We also reserve the right to change our notice of privacy practice to make the terms of any change effective for all protected health information that we maintain (including information created or obtained prior to the date of the effective date of change). Please list anyone you wish us to disclose your healthcare information to on this form. Please be aware that anyone requesting your information that is not listed on this form will need approval from you prior to the information given. Please read the enclosed Privacy Act prior to signing the acknowledgement and consent form.

Please list names of to who protected health information may be given.

\_\_\_\_\_

\_\_\_\_\_

I have read and fully understand the Financial Policy and Protected Health Information Privacy Act. I have read the privacy practice for Cardin & Miller Physical Therapy and have authorized them to use and disclose health information regarding my care for treatment, payment and healthcare operation purposes.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian or POA

## Cardin & Miller Physical Therapy Privacy Act on Protected Health Information

THIS NOTICE DESCRIBES HOW MEDIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REIEW IT CAREFULLY.

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with your family members or friend involved in your care if you do not object; we may use your PHI in an emergency situation when you may not be able to express yourself; we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example, by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to you health or safety or health or safety of the public. If you are in the Armed Forces, we may release information about you when it is determined to be necessary by the appropriate military command authorities. We may release information about you for worker's compensation or other similar programs that provide benefits for work related injury or illness. Your authorization is required before you PHI may be used or disclosed by us for other purposes.

1) *Uses and Disclosures:* We will use your PHI for the purposes of treatment, payment, health care operations and other special uses.

\* **Treatment** includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists.

\* **Payment** includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical records to determine that your care was necessary.

\* **Health Care Operations** (within our facility) includes utilization of your records to monitor the quality of care being given at our facility of for business planning activities.

\* **Other Special Uses** includes our practice using your PHI to send you and appointment reminder or to inform you of our other health related products or services.

2) *Your Privacy Rights:*

\* **Restrictions:** You have the right to request restrictions on how your PHI is used.

\* **Confidential Communications:** You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

\* **Access to PHI:** You have the right to request an amendment to be made to your PHI if you disagree with what it says about you. This request must be in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree and that will become part of your record. We may not amend part of your medical record that we did not create.

\* **Accounting of Disclosure:** After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment or health care operations of for which we have obtained authorization.