

**CAM Physical Therapy and Wellness Services, LLC Patient Registration (Please Print)**

Today's Date \_\_\_\_\_ E-mail Address \_\_\_\_\_

Name (Last, First, M.I.) \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Alternate Phone # (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

SSN \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_ Referring Doctor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**In case of emergency please contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_

**Primary Insurance Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

ID/Policy # \_\_\_\_\_

Group Name/# \_\_\_\_\_

Subscriber \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Secondary Insurance Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

ID/Policy # \_\_\_\_\_

Group Name/# \_\_\_\_\_

Subscriber \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Worker's Compensation Information**

Date of Injury \_\_\_\_\_

W/C Carrier \_\_\_\_\_

Address \_\_\_\_\_

Claim # \_\_\_\_\_

Adjuster \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

**MVA Information**

Date of Accident \_\_\_\_\_

Driver (Yes) \_\_\_\_\_ (No) \_\_\_\_\_

Auto Insurance \_\_\_\_\_

Policy # \_\_\_\_\_

Claim # \_\_\_\_\_

Insurance Agent \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

**Attorney Information**

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

# **CAM Physical Therapy and Wellness Services, LLC**

## **Patient Authorization/Consent Form**

I, the undersigned do hereby voluntarily consent to such diagnostic procedures and care as deemed medically necessary or recommended by the treating and/or referring medical facility and/or physician.

Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

### **Notice of Privacy Practices**

CAM Physical Therapy and Wellness Services, LLC has incorporated a complete description of the facility's Privacy Practices and all patients have the right to review and/or receive a copy of the HIPAA Notice of Privacy Practices as deemed necessary to conform to State and Federal Laws.

**I am aware of CAM Physical Therapy and Wellness Services LLC.'s notice of privacy practices and I understand that I may request a copy of this document at any time.**

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any information, including medication information for this and any related claims, to Medical Service of D.C., (or in the case of Medicare Part A or B benefits, to the Social Security Administration and Health care Finance Administration, and all third party carriers). I understand my protected health information will remain confidential and this consent is required solely for disclosure of health information for treatment, payment and health care operations. I permit a copy of this consent to be used in place of the original. I understand I have the right to request that the provider restrict how protected health information is used or disclosed to carry out treatment, payment or health care operations. However, I understand the provider does not have to agree to the requested restriction(s) therefore, the restriction is binding on the provider. This consent form may be revoked by me provided it is done in writing with the exception, the provider has not already acted upon the consent.

Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

### **PAYMENT RESPONSIBILITY:**

#### Authorization of Assignment and Payment:

I, the undersigned hereby authorize *CAM Physical Therapy and Wellness Services LLC.* to apply for benefits on my behalf for covered services rendered. **I hereby authorize and request payments from my insurance carrier to be made directly to *CAM Physical Therapy and Wellness Services LLC.***

I further understand that I am financially responsible for charges not covered by this assignment. I understand that payment is due at the time services are rendered inclusive of, but not limited to, any personal responsibilities such as co-payments and deductibles. I permit a copy of this authorization to be used in place of the original. I am aware that *insurance payment/reimbursement may not cover the total balance due* for the medical services I received. *I agree to pay any outstanding balance on my account.* I also agree to pay any and all legal expenses and fees incurred for the purpose of collecting payment for any outstanding balance on my account, if such action is deemed necessary. I agree to pay any additional fees and/or costs incurred in order to collect payments on my account if the balance is outstanding beyond ninety (90) days including all legal and court costs on my account(s). *I waive my rights under Maryland's statute of limitation should reconciliation of my account extend beyond three (3) years from the date of service.*

Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

**Appointments:**

I CERTIFY AND I UNDERSTAND THAT I MUST PROVIDE **AT LEAST 24 HOUR NOTIFICATION PRIOR TO A SCHEDULED APPOINTMENT IF I AM UNABLE TO KEEP THAT APPOINTMENT.**

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a \$25.00 fee. In instances of repeated non-compliance with your scheduled visits (2 unkept appointment), we also reserve the right to discontinue care and will inform your physician, attorney, and workers compensation carriers and its representatives of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation plan.

Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

**Medicare Waiver Statement (If Applicable):**

Anyone who misrepresents or falsifies essential information requested by this form may, upon conviction, be subject to fine and imprisonment under Federal Law. Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a)(1) of the Medicare Law.

I, the undersigned agree to be responsible, whether through another insurance or otherwise, for payments of therapy services. I acknowledge that no Medicare limiting charge limits will apply and that other supplemental insurance plans may elect not to make payments for such services.

Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

**Insurance Benefits**

I understand that it is my responsibility to know the benefits and requirements of my insurance company. CAM Physical Therapy and Wellness Services, LLC makes all attempts to stay informed with contracted insurances but, each coverage is unique and subject to change without notice to us.

As a service to you CAM Physical Therapy and Wellness Services, LLC has called your insurance company to verify benefits for services to be rendered by our staff. Those benefits as explained to us by your insurance company are as follows:

Deductible \$ \_\_\_\_\_ met/not met.

You are responsible for \_\_\_\_\_% of usual and customary charges and/or,

\$ \_\_\_\_\_ Co-pay per visit.

**Please understand that this is not a guarantee of payment is subject to medical review. If you should have any further questions regarding payment or coverage for services please contact your insurance company customer service department.**

Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

# Medical History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**1. Current Condition:**

a. Describe the problem(s) for which you are seeking physical therapy

\_\_\_\_\_

b. When did the problem(s) begin?

\_\_\_\_\_

c. What caused the problem(s)?

\_\_\_\_\_

d. Is this a recurring problem? yes\_\_\_ no\_\_\_

If yes, what did you do for the problem(s)?

\_\_\_\_\_

e. How long did the problem(s) continue?

\_\_\_\_\_

f. What makes the problem(s) worse?

\_\_\_\_\_

g. What makes the problem(s) better?

\_\_\_\_\_

h. What are your goals for physical therapy?

\_\_\_\_\_

i. Are you seeing anyone else for this problem?

\_\_\_\_\_

**2. General Health Status:**

a. Please rate your health:      Excellent                      Good                      Fair                      Poor

**3. Medical History (Check All That Apply)**

Night Sweats Or Fever	Mouth Sores	Back Injury	Any Lung Problem
Recent Weight Loss / Gain	Change In Voice	Joint Injury/Pain	Shortness of Breath
Convulsions	Hoarseness	Arthritis	Hay Fever / Asthma
Memory Loss	Difficulty Swallowing	Broken Bones	Bronchitis/Pneumonia
Numbness / Tingling	Heart Problems	Blood Disease	Tuberculosis / Persistent Cough
Fainting / Dizzy Spells	Chest Pain	Bleed Easily	Cough Up Blood
Headaches	Rheumatic Fever	Anemia	Smoker / Ex-Smoker
Paralysis	Irregular Heart Beat	Diabetes	___ Years___ Cigarettes (Pk/Day)
Stroke / Blood Clot	Heart Murmur	Thyroid Problems	___ Pipe (Bowls/Day)
HIV Positive / AIDS	High Blood Pressure	Cancer	___ Quit (Year)
Diabetes	Swollen Ankles	Change In Wart Or Mole	Exposed to Second-Hand Smoke
Pacemaker	Varicose Veins	Liver Disease	___ Work / ___ Home
Pregnancy	Ulcers / Hernia	Swollen Ankles	Stress /Depression
Vision Problems	Change In Bowel/Bladder	Drink Alcohol	Bladder Infections
Color Blindness	Sinus Problems	__ Drink Per Day	Kidney Problems
Cataracts / Glaucoma	Nausea / Vomiting (Other Than Flu)	__ Drinks Per Week	Prior Drug / Alcohol Treatment
Balance Problems	Blood In Urine	Trouble Sleeping	Noise In Ears / Hearing Problems

**3a. Medical History (Continued)**

Surgeries	
Prescription Medications	
Non-Prescription Medications	
Medication Allergies	

Medical Devices (Prosthesis)	
Additional Medical History	

**4. Other Clinical Tests – Within the past year have you had the following tests (circle all that apply)**

<input type="checkbox"/>	Angiogram	<input type="checkbox"/>	Mammogram
<input type="checkbox"/>	Arthroscopy	<input type="checkbox"/>	MRI
<input type="checkbox"/>	Biopsy	<input type="checkbox"/>	Myelogram
<input type="checkbox"/>	Blood Tests	<input type="checkbox"/>	NCV (nerve conduction velocity)
<input type="checkbox"/>	Bone Scan	<input type="checkbox"/>	Pap Smear
<input type="checkbox"/>	Bronchoscopy	<input type="checkbox"/>	Pulmonary Function Test
<input type="checkbox"/>	CT Scan	<input type="checkbox"/>	Spinal Tap
<input type="checkbox"/>	Doppler Ultrasound	<input type="checkbox"/>	Stool Tests
<input type="checkbox"/>	Echocardiogram	<input type="checkbox"/>	Stress Test (e.g. treadmill, bicycle)
<input type="checkbox"/>	EEG (electroencephalogram)	<input type="checkbox"/>	Urine Tests
<input type="checkbox"/>	EKG (electrocardiogram)	<input type="checkbox"/>	X-Rays
<input type="checkbox"/>	EMG (electromyogram)	<input type="checkbox"/>	Other:

I have completed this form truthfully and to the best of my ability.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Notice of Privacy Practices

**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.**

**1) Uses and Disclosures** We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

**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. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

**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 record to determine that your care was necessary.

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

**Auto Insurance:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to auto insurance or other similar programs established by law.

**Worker's Compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

### **Other Special Uses**

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

### **Uses and Disclosures Required by Law**

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 a family member 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, and 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.

Source: American Physical Therapy Association.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

## **2) Your Privacy Rights**

### **Restrictions**

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

### **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 a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

### **Amendments**

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made 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 that will become part of your record. We may not amend parts of your medical record that we did not create.

### **Accounting of Disclosures**

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 or for which we have obtained authorization.

Source: American Physical Therapy Association.

## **Complaints**

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services. To find additional information about filing a complaint, go to <http://hhs.gov> or by calling 866-627-7748.

## **Our Duty to Protect Your Privacy**

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

## **Privacy Contact**

If you would like more information about our privacy practices or to file a complaint you may contact:

Name: Maria A. Thomas

Title: Privacy Officer

Address: 3311 Toledo Terrace  
Suite A-1  
Hyattsville, MD 20782

Phone: (301) 853-0093

**Effective Date: August 4, 2003**

This Notice will take effect on April 14, 2003

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Patient Signature

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Date

**The Federal Department of Health and Human Services (DHHS):** Under the privacy standards, we must disclose our health information to DHHS as necessary for them to determine compliance with those standards.

**Notice of Privacy Practices Availability:** This notice will be prominently posted in the office where registration occurs. Patients will be provided a hard copy.

I have read and understand all the information stated above. Any questions I had regarding this policy were answered to my satisfaction.

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**Signature of Patient**

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**Effective Date**

List any restrictions below and initial:

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