

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 nurses, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons as it may relate to my treatment.

I authorize Physical Therapy & Pain Management Center, LLC. To obtain medical records and/or professional information from my physician and/or 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 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 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 purpose of treatment, payment and health care operations.

Payment Guarantee

I agree to pay Physical Therapy & Pain Management Center, LLC, for the services and/or products provided to me or the party named above, If any law, such as workers' compensation, or insurance contracts prohibits payment for these services and/or products I will co-operate and assist in the provision of information, authorization, release, 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 its not a guarantee of coverage. If any information provided by my insurance is not accurate or the insurance company changed its coverage, or that coverage is insufficient, I will be responsible for payment of any unpaid portions 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 treatment unless agreed to in writing 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 the information as explained, I approve of the Assignment of Benefits, acknowledge I have received the HIPAA Notice of Privacy Practices and guarantee payment. I have been informed of the risks of contracting a virus, such as COVID-19, and have been informed of the methods used to minimize this risk by this establishment.

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 know or have you ever had any of the following medical conditions:

	YES	NO		YES	NO
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Infections	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Metal in body	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Clotting/DVT	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Cold/Hot	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

If you answered "yes" to any of the above, please explain and give approximate date 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 _____
 Patient/Parent/Guardian Signature

 Date

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 Authorize to Use or Disclose Information

Information listed above will be used or disclosed by:

Physical Therapy and Pain Management Center, LLC.

Name of Person/Organization

Persons to Whom Information May be Disclosed

Information described above maybe 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's authorize 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 and 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

Name of Patient Representative

Date

Relationship of Patient Representative to Patient

Dear Patient,

It is the expectation at the time of any appointment for physical therapy is made that you have all good intentions of keeping that appointment. It is also 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 ant of your rehabilitation goals requires your attendance and diligent efforts. Failure to attend schedule appointments creates the risk of not fulfilling those goals and may have 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 a rare event, and not a repeated one.

For the benefit of all our patients who need to have their appointments at a specific time 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 and a no-show fee of \$40 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 therapist.

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 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, 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.



PHYSICAL THERAPY AND PAIN MANAGEMENT CENTER, LLC

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Silver Spring, MD 20904
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Fax 301.592.8300
www.whiteoaktherapy.com

College Park Physical Therapy & Hand Rehabilitation
4595 Van Buren Street, Suite 210
Riverdale Park, MD 20737
Phone 301.864.0009
Fax 301.864.0012
www.collegeparktherapy.com

Patient Consent to Automated Appointment Reminders

As a courtesy to our patients an automated reminder will be sent 24 hours in advance of your upcoming appointment. Please enter either an e-mail address or cell phone number indicating your preference for the reminder.

Physical Therapy and Pain Management Center, LLC will not be responsible for any additional charges incurred with your cell phone provider due to any overages for data charges or text plan limitations. You must notify us immediately of any changes to your information to protect your private health information.

E-mail address: _____
(Please print)

or

Cell Phone Number: _____

Cell Phone Provider (check one box below):

AT&T MetroPCS Sprint T-Mobile

Verizon Xfinity Other: _____

Patient Name: _____
(Please print)

Patient Date of Birth: _____

Patient or Legal Guardian Signature

Date