Previous Patient? Y / N **Date: ______________________________**

Last Name _____________________________ First Name __________________________ MI_____________

Street Address ____

City ______________________ State _________ Zip _____________ Ailment_____________________

Telephone: Home (______) _______-________ Cell (______) _______-________

Work (______) _______-________ E-Mail ____

Would you like to receive appointment reminders by E-mail? Y / N

Date of Birth ______/______/______ Social Security # ______-_____-______

Emergency Contact _________________________ Phone (_____) ______-__________

Referring Physician ___________________________ PCP___________________________________

How Did You Hear About Us? ( )Ad ( )sign ( )doctor ( )ins. Co. ( )website ( )friend____________

Appt time needed: ____ Flexible? Y / N

Insurance: ( ) BC/BS ( ) Medicare ( ) Cigna ( ) Auto ( ) Workers Compensation ( ) Other

Do you have secondary insurance? ( ) Yes ( ) No

EMPLOYER INFORMATION

Employer Name ____

Work Telephone (______) _______-_________ Job Title ___________________________________

Street Address ____

City _____________________ State _____________ Zip ____________________

RESPONSIBLE PARTY INFORMATION

Who is the Insured?: Self ( ) Spouse ( ) Parent ( ) Other ( )

Last Name ____________________________ First Name ___________________________ MI ___________

Street Address ____

City __________________________________ State ____________________Zip ________________

Home Telephone (_____) _____-_______ Work Telephone (_____) ______-_______

Date of Birth _____/_____/_____ Social Security # ________-_____-________

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to *RM Health Services, Inc. dba Purcellville Orthopedic Physical Therapy*. I also acknowledge by signing below I hereby accept the terms and agreements made by the attached *RM Health Services, Inc. dba Purcellville Orthopedic Physical Therapy*-Patient Registration and Consent for Medical Treatment Form.

__________________________________ ______________________ ______________________

Patient/Responsible Party Signature Relationship Date

PATIENT NAME:________________________

PRIMARY INSURANCE INFORMATON/VERIFICATION

( )Workers Compensation ( )Auto/No Fault ( )Medicare ( )BC/BS ( )Commercial ( )Other

Date of Injury____________________________ Was injury related to accident? ( ) Yes ( ) No

Insurance Company____

Policy/Claim #___________________________ Group #___________________________________

Case Manager____

Insurance Billing Address____

City____________________________________ State________________ Zip Code________________

Telephone: (______) ________-_____________ Fax: (______) ________-_____________

Effective Date____________________ Maximum # of Visits____________/___________

PRECERT REQUIRED ( ) Yes ( ) No REFERRAL REQUIRED ( ) Yes ( ) No

% Coverage____________ Co-Pay______________ In Network__________ Out of Network_____

Deductible_____________ Amount Met__________ Out of Pocket____________

Authorization #_________________________________ Start Date____________ End Date_____________

Comments____

Spoke with____________________________________ Date______________________

SECONDARY INSURANCE INFORMATON/VERIFICATION

( )Workers Compensation ( )Auto/No Fault ( )Medicare ( )BC/BS ( )Commercial ( )Other

Date of Injury____________________________ Was injury related to accident? ( ) Yes ( ) No

Insurance Company____

Policy/Claim #___________________________ Group #___________________________________

Case Manager____

Insurance Billing Address____

City____________________________________ State________________ Zip Code________________

Telephone: (______) ________-_____________ Fax: (______) ________-_____________

Effective Date____________________ Maximum # of Visits____________/___________

PRECERT REQUIRED ( ) Yes ( ) No REFERRAL REQUIRED ( ) Yes ( ) No

% Coverage____________ Co-Pay______________ In Network__________ Out of Network_____

Deductible_____________ Amount Met__________ Out of Pocket____________

Authorization #_________________________________ Start Date____________ End Date_____________

Comments____

Spoke with____________________________________ Date______________________

RM Health Services, Inc.
dba Purcellville Orthopedic Physical Therapy
125 Hirst Road, Suite 1A
Purcellville, VA 20132
540-751-1970 fax 540-751-1971
www.rmhealthservices.com

Patient Registration and Consent for Medical Treatment

1. **<u>Consent for Health Care Services</u>**: I authorize consent for medical treatment at Purcellville Orthopedic Physical Therapy.
2. **<u>Authorization for Release or Information</u>**: Purcellville Orthopedic Physical Therapy may release information from my medical records to any health care provider involved in my care and treatment. Purcellville Orthopedic Physical Therapy may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Purcellville Orthopedic Physical Therapy is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **<u>Financial Agreement</u>**: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Purcellville Orthopedic Physical Therapy, ***which are not paid***, by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from Purcellville Orthopedic Physical Therapy, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Purcellville Orthopedic Physical Therapy. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.
4. **<u>Preauthorization Requirements</u>**: I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Purcellville Orthopedic Physical Therapy charges.
5. **<u>Assignment for Direct Payment</u>:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Purcellville Orthopedic Physical Therapy charges not paid.
6. **<u>Charge for No Show/Cancellation without 24-hour notice</u>**: I understand that 24-hour notice is required for canceling an appointment, and I will be charged a $25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

I acknowledge that:
- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for all payments and/or co-payments that are due at the time of service.
- I have received a copy of Purcellville Orthopedic Physical Therapy HIPAA Policy.

____________________________________ __________________________
Signature of Patient or Legally Responsible Person **Name (PRINT)**

____________________________________ __________________________
Relationship/Reason Why Patient is Unable to Sign **Date**

INSURANCE WAIVER

I understand that if Purcellville Orthopedic Physical Therapy is not an in-network participating provider for my insurance company. I agree to pay all charges and will submit on my own for reimbursement of any charges from my insurance company.

______________________________	______________________________
Signature of Patient or Legally Responsible Person	**Name (PRINT)**
______________________________	______________________________
Relationship/Reason Why Patient is Unable to Sign	**Date**

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www.rmhealthservices.com

Provider 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!

Key Issues

Uses and Disclosures: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we ask for your written authorization before using or disclosing any identifiable health information about you.

Your Rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your records is incorrect, you have the right to request that we correct the existing information.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the US Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, Please contact:
Owner – Richard Mead, PT
125 Hirst Road, Suite 1A
Purcellville, VA 20132
540-751-1970
rcmpt@comcast.net

Further Details

1. Uses and Disclosures of Protected Health Information

Following are examples of the types of uses and disclosures of your protected health care information that the provider is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health insurance company or governmental plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support our business activities. For example, when we review employee performance, we may need to look at what an employee has documented in your medical record.

Business Associates: We may share your protected health information with a third party 'business associate' that performs various activities (e.g., billing, transcription services). Whenever an arrangement between us and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Marketing: We may use or disclose certain health information in the course of providing you with information about treatment alternatives, health-related services, or fund-raising. You may contact us to request that these materials not be sent to you.

Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing.

Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Facilitv Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Emergencies: In an emergency treatment situation, we will provide you a Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your protected health information if we have attempted to obtain acknowledgement from you of our Notice of Privacy Practices but have been unable to do so due to substantial communication barriers and we determine, using professional judgment, that you would agree.

Without Opportunity to Object
We may use or disclose your protected health information in the following situations without your authorization or opportunity to object:
Public Health: for public health purposes to a public health authority or to a person who is at risk of contracting or spreading your disease.
Health Oversight: to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
Abuse or Neglect: to an appropriate authority to report child abuse or neglect, if we believe that you have been a victim of abuse, neglect, or domestic violence.
Food and Drug Administration: as required by the Food and Drug Administration to track products.
Legal Proceedings: in the course of legal proceedings.
Law Enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.
Coroners. Funeral Directors. and Organ Donation: for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.
Research: to researchers when their research has been approved by an Institutional Review Board or Privacy Board.
Soldiers. Inmates. and National Security: to military supervisors of Armed Forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.
Workers' Compensation: to comply with workers' compensation laws.
Compliance: to the Department of Health and Human Services to investigate our compliance.
In general, we may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

2. Your Rights

You have the right to:
inspect and copy your protected health information. However, we may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding.
request a restriction of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, but if we do agree, then we must act accordingly.
request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.
ask us to amend your protected health information. You may request an amendment of protected health information about you. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.
receive an accounting of certain disclosures we may have made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.
obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Acknowledgement of receipt of Notice of Privacy Practices:

Please sign your name and print your name and date on this acknowledgement form. Then detach the form from the Notice along the dotted line and return your signed acknowledgement to the receptionist.

Signature: ____

Printed name: ______________________________________

Date:___________________________

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Purcellville, VA 20132
540-751-1970 fax 540-751-1971

MEDICAL INTAKE FORM

Patient ______________________________ Date of Birth: _________________ SS# _______________
Emergency Contact: ____
Relationship:_______________________________________ Telephone #: __________________________
Referring Physician:________________________________ Telephone #: __________________________
Family Physician / Internist:_________________________ Telephone #: __________________________

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE / HAVE HAD :

1. High Blood Pressure	yes	no	28. Blood in Stool / Ulcers	yes	no
2. Heart Disease Heart Attack	yes	no	29. Abdominal Pain	yes	no
3. Chest Pains / Angina	yes	no	30. Thyroid Problems	yes	no
4. High Cholesterol	yes	no	31. Polio / Muscle Disease	yes	no
5. Pacemaker	yes	no	32. Seizures	yes	no
6. Shortness of Breath	yes	no	33. Migraine/Cluster Headaches	yes	no
7. Asthma	yes	no	34. TMJ Disorders	yes	no
8. Allergies	yes	no	35. Chills/Fever/Sweats	yes	no
9. Chronic Bronchitis	yes	no	36. Chronic Headaches	yes	no
10. Blood Disorders	yes	no	37. Swelling of Extremities	yes	no
11. Emphysema	yes	no	38. Sleep Disorders	yes	no
12. Bleeding/Bruising	yes	no	39. Depression	yes	no
13. Anemia	yes	no	40. Fibromyalgia	yes	no
14. Diabetes	yes	no	41. Chronic Fatigue Syndrome	yes	no
15. Hypoglycemia	yes	no	42. Lyme's Disease	yes	no
16. Lightheadedness	yes	no	43. Chronic Pain	yes	no
17. Dizziness	yes	no	44. Night Pain	yes	no
18. Concussion	yes	no	45. Unexplained Pain	yes	no
19. Fainting Disorders	yes	no	46. Unexplained Weight Loss	yes	no
20. Anxiety/Panic Attacks	yes	no	47. Cancer/Tumors/Growths	yes	no
21. Arthritis/Joint Pain	yes	no	48. History of Smoking	yes	no
22. Artificial Joints	yes	no	49. Are you pregnant?	yes	no
23. Kidney Disease/Stones	yes	no	50. Gynecological Disorders	yes	no
24. Hepatitis	yes	no	51. Bladder Incontinence	yes	no
25. Spinal Cord Injury	yes	no	52. Bowel Incontinence	yes	no
26. Traumatic Brain Injury	yes	no	53. Fractures	yes	no
27. Ulcers	yes	no	Date:__________Area:____________		
			Date:__________Area:____________		

CURRENT MEDICATIONS:____
ALLERGIES:
A. To Medications: ____
B. To Other Substances: ____
SURGERY (S) Include Dates: ____
X-RAYS, MRI, CAT SCANS (Include Area & Dates): ____

SIGNATURE:____Date: ___________________________________