

BERKSHIRE ORTHOPEDIC ASSOCIATE/PHYSICAL THERAPY

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

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

Have you been treated by a chiropractor or have you received physical therapy, occupational or speech therapy within the past year?      Yes \_\_\_\_\_      No \_\_\_\_\_

If yes, please list where, when, how many visits you had and why were you treated (body part)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I UNDERSTAND THAT IF THIS INFORMATION IS NOT TRUE, I WILL BE BILLED FOR ANY PHYSICAL THERAPY NOT COVERED BY MY INSURANCE COMPANY.

\_\_\_\_\_

SIGNATURE

# BERKSHIRE ORTHOPEDIC PHYSICAL THERAPY

|   |  |  |         |        |                      |                                 |                        |       |
|---|--|--|---------|--------|----------------------|---------------------------------|------------------------|-------|
| PATIENT NAME: LAST  |  |  | FIRST   |        | M.I.                 | MARITAL STATUS: M S D W         |                        |       |
| DATE OF BIRTH   |  |  | AGE     | WEIGHT | HEIGHT               |                                 | HOME PHONE             |       |
|   |  |  |         |        | FT                   | IN                              | ( )                    |       |
| STREET ADDRESS  |  |  |         | CITY   |                      | ST                              | ZIP                    | SEX   |
|   |  |  |         |        |                      |                                 |                        | M F   |
| SPOUSE'S NAME: LAST                                       |  |  | FIRST   |        | M.I.                 | ADDRESS IF DIFFERENT FROM ABOVE |                        |       |
|   |  |  |         |        |                      | STREET CITY STATE ZIP           |                        |       |
| PARENT'S NAME IF PATIENT IS MINOR                         |  |  |         |        | OCCUPATION           |                                 | WORK PHONE & EXT       |       |
| FATHER  |  |  |         |        | MOTHER               |                                 |                        |       |
| PATIENT'S EMPLOYER (FATHER'S IF PATIENT IS A MINOR)       |  |  |         |        | CITY                 |                                 | ST                     | ZIP   |
| EMPLOYER'S STREET ADDRESS                                 |  |  |         |        |                      |                                 |                        |       |
| SPOUSE'S EMPLOYER (MOTHER IF PATIENT IS A MINOR)          |  |  |         |        | OCCUPATION           |                                 | WORK PHONE & EXT       |       |
| EMPLOYER'S STREET ADDRESS                                 |  |  |         |        | CITY                 |                                 | ST                     | ZIP   |
| EMERGENCY CONTACT   |  |  |         |        | PRIMARY PHONE NUMBER |                                 | SECONDARY PHONE NUMBER |       |
|   |  |  |         |        |                      |                                 |                        |       |
| ARE YOU A FORMER PATIENT? YES NO IF YES, WHAT YEAR? _____ |  |  |         |        |                      |                                 |                        |       |
| HOW DID YOU HEAR OF OUR PRACTICE? _____                   |  |  |         |        |                      |                                 |                        |       |
| FAMILY DOCTOR   |  |  | ADDRESS |        | CITY                 | ST                              | ZIP                    | PHONE |
|   |  |  |         |        |                      |                                 |                        |       |

Insurance authorization and assignment: I hereby assign all medical and/or surgical and major medical benefits including auto, medicare, private, worker's compensation and other health plans to which I am entitled to B.O.P.T.. I authorize said assignee to release all information necessary to secure these benefits and understand that I am financially responsible for all charges whether or not paid by said insurance. The assignment will remain in effect until revoked by me in writing and a photocopy is to be considered as valid as the original.

I understand that I am responsible for my bill regardless of insurance carrier decisions or legal cases pending. I permit use of this authorization on all my insurance submissions.

I authorize payment direct to Berkshire Orthopedic Physical Therapy.

I permit a copy of this authorization to be used in place of the original.

If payment is made directly to me by my insurance company, I understand that I am responsible to bring both the explanation of benefits and payment to Berkshire Orthopedic Physical Therapy as soon as it is received.

If a deductible has not been previously met for the year, I understand I am responsible for payment of the deductible in full.

Returned checks and balances older than 30 days may be subject to additional collection fees.

I authorize Berkshire Orthopedic Physical Therapy to provide physical therapy treatment according to my physician's prescription and the judgement of the physical therapist providing my care.

\_\_\_\_\_ MONTH-DAY-YEAR

SIGNATURE OF PATIENT (GUARDIAN IF PATIENT IS A MINOR)

# HIPAA Notice of Privacy Practices

I, \_\_\_\_\_, understand that as part of my health care, Berkshire Orthopedic Assoc., Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health care professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services were actually provided, and
- A tool for routine health operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Berkshire Orthopedics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Berkshire Orthopedics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Berkshire Orthopedics change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand the terms of this consent.

\_\_\_\_\_  
Patient's Signature (authorized representative signing for the patient)

\_\_\_\_\_  
Date

- GEORGE E. SEBONIA**
- Consent received by \_\_\_\_\_ on \_\_\_\_\_.
  - Consent refused by patient, and treatment refused as permitted.
  - Consent added to the patient's medical record on \_\_\_\_\_.