Medicare and others insurances requires therapists to screen the following topics.

Please answer the following questions to the best of your ability.

Please circle:

Have you experienced a fall within the last year?	Yes	No
Did it result in an injury?	Yes	No
Do you use tobacco products?	Yes	No
Have you experienced elder abuse?	Yes	No

How would you rate your pain on a scale from 0 to 10, 0 being No pain at all

0 1 2 3 4 5 6 7 8 9 10

Weight________

Height________

Please list brief medical history: example: Arthritis, Diabetes, Hypertension, etc.

BERKS HAND THERAPY CENTER
1435 PENN AVENUE
WYOMISSING PA 19610
610-376-1902

PROVIDER, PATIENT AGREEMENT

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

We accept a number of insurances, including workmans compensation benefits. We will submit your insurance claims to your insurance, but there is no guarantee that your insurance will pay your claim. If your insurance does not pay for services rendered or declines payment of the claim or pays partial, it is your responsibility to pay for what is not paid.

All co-pays are due at time of service, which can be paid by cash, check, or credit card.

After 60 days if we have not received payment from your insurance, we will contact you to let you know we have not received payment.

At 90 days we will ask you to come in and sign a financial agreement, which will state what you owe and what payment arrangement are agreeable to both you and our facility.

After 120 day if we still do not receive payment for our services and have not heard from you. We will have no other choice but to start collections.

Berks Hand Therapy Center

Mark J [illegible], OTR/L ____________ Date ____________

Patient Signature

______________________________ Date ____________

By signing you have read and agree to our policy

BERKS HAND THERAPY CENTER
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
JULY 1, 2003

Berks Hand Therapy Center is now entering the era of HIPAA. We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice regarding the HIPAA rules and regulation. The information will remain in effect until such time as it is revised. We reserve the right to change this notice providing it is permitted by HIPAA Laws. Once the changes have been made, they will be available to our patients.

It has been and will continue to be our policy to protect our patients privacy. We may disclose your health information for purpose of treatment, payments/insurance, place of employment/workers comp, professionals involved in your care, family/friends, facilities involved with your care, emergency situations, research, with your signed permission only. We will NOT use your health information for marketing purposes. We may disclose your health information to the appropriate authorities if we believe you are a victim of abuse, neglect, domestic violence and/or other crimes, if we feel that any of these pose a serious health threat. We may disclose your health information to military personnel, correctional institutes, and law enforcement officials.

We may leave messages on your answering machine and/or with a family member/friend regarding appointments and account billing. Also, by signing this, it gives Berks Hand Therapy Center permission to call your home.

It will not be our responsibility to determine if you are a dependent. On your 18th birthday the patient is now responsible for his/her health information. Written consent by the 18 year old must be received in order to provide information to an adult.

You have the following rights as a Berks Hand Therapy Center patient:

You may inspect and copy your medical records that pertain to any decisions regarding your health care (We must receive a signed release stating that you need your medical records copied); If you feel your medical information is incorrect you must notify the office and ask us to amend them; (We must receive a signed release and the reason why you feel these should be amended)

We will NOT deny any reasonable requests and we will try to accommodate you in any way that pertains to your medical information. We will provide you with the highest quality if care, at all times.

I________________________________hereby acknowledge that I have received a copy of the Berks Hand Therapy Center notification of the HIPAA of 1996.

Patients Signature____Date____________________

Parent/Guardian____Date____________________

Witness____Date____________________

REFUSAL TO SIGN

Patient/Legal/Personal Representative refused to sign acknowledgement

Personal Signature____Date____________________

Reason for refusal____

Witness____Date____________________

Thank you for allowing us to participate in your care.

BERKS HAND THERAPY CENTER
1435 PENN AVENUE
WYOMISSING, PA 19610

DATE:______________________

PATIENT NAME______________________________________ BIRTHDATE____________

ADDRESS____

CITY____STATE/ZIP______________

E-MAIL____

HOME NUMBER__________________________CELL NUMBER____________________

WORK NUMBER__________________________SS#_____________________________

EMERGENCY CONTACT PERSON____________________________NUMBER______________

PARENT OR GARDIAN(IF MINOR)____

EMPLOYER____POSITION_____________

REFER. DOCTOR________________________________FAMILY DOCTOR_____________

PRIOR THERAPY: YES_______NO_______ IF YES WHERE_____________________________

ASSIGNMENT OF BENEFITS

I hereby authorize Berks Hand Therapy Center to accept assignment of my insurance for professional service that are rendered to me. I also give permission to Berks Hand Therapy Center to release any information pertaining to my treatment in this office to my insurance,(primary/secondary), Social Security office, physicians who are treating me, facilities involved in treating and my place of employment, should it be a workmens' comp claim. At any given time, I have the right to obtain copies of my records should the need arise

The remaining amount co-pay/deductible will be my/our responsibility. However, if I have NO insurance I am responsible for services rendered at the time of service.

SIGNATURE____DATE____________

WITNESS____DATE____________