BERKS HAND THERAPY CENTER

1435 PENN AVENUE

WYOMISSING, PA 19610

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE/ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELLPHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT OR GUARDIAN (IF UNDER AGE OF 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSITION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAMILY DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIOR THERAPY: YES \_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_ IF YES WHERE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE PROVIDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE ID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY (EX: ARTHRITIS, DIABETES, HYPERTENSION, ETC):

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

DO YOU USE TOBACCO PRODUCTS: YES\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_

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 workers’ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BERKS HAND THERAPY CENTER

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Berks Hand Therapy Center works diligently to adhere to federal and state laws to maintain the privacy of your health information. This document provides notice regarding the HIPAA rules and regulations. We have always and will continue to strive to protect our patients’ privacy. We may disclose your health information for the purpose of treatment, payments/insurance, place of employment/workers comp, professionals and facilities involved in your care, research, family/friends and emergency situations 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 threat to your health. 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 permission to Berks Hand Therapy Center to call your home.

If the patient is older than 18, he/she is responsible for his/her health information. Written consent by the patient, older than 18, must be received in order to provide information to a family member/guardian.

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

You may inspect and receive copies of your medical records that pertain to any decisions regarding your health care. If you feel your medical information is incorrect you must notify the office and request amendments. To fulfill these requests the office will need a signed release stating the information you are requesting and any changes you believe necessary.

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

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby acknowledge that I have read, understood and consent to the information provided in this document as a patient of Berks Hand Therapy Center.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Thank you for allowing us to participate in your care!