

## **Confidential Patient Data**

Patient Name _____	Date of onset of symptoms: _____
Address _____	
City _____	State _____ Zip _____ Home Phone _____
Cell Phone# _____	Birth Date _____
Employer _____	Occupation _____
Office Phone _____	Marital Status _____ Spouse's Name _____
Emergency Contact _____ Phone _____	
May we contact you by E-Mail to keep you up to date with periodic health-related newsletters and news about our facility? _____	
If Yes, please give us your E-Mail address: _____	

### **How did you hear about our facility?**

Physician \_\_\_ Insurance Provider List \_\_\_ Employer \_\_\_ Verizon Yellow Pages \_\_\_ The Yellow Book \_\_\_  
Website \_\_\_ Insurance company \_\_\_ Rehab nurse \_\_\_  
Relative/Friend (please name) \_\_\_\_\_  
Other (please list) \_\_\_\_\_

Were you injured in an auto accident? Yes \_\_\_ No \_\_\_ Date of accident \_\_\_\_\_  
Were you injured on the job? Yes \_\_\_ No \_\_\_ Date of injury \_\_\_\_\_  
Are legal procedures pending? Yes \_\_\_ No \_\_\_  
If yes, please give attorney's name, address, and phone number: \_\_\_\_\_

### **Billing Information**

**Private Insurance – Please show us your insurance card**

**Do you have a secondary insurance – if so, please show us that card also**

#### **Worker's Compensation/Auto Accident Claims**

Insurance Name \_\_\_\_\_ Claim#: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Adjustor Name \_\_\_\_\_ Phone \_\_\_\_\_  
Fax \_\_\_\_\_

## *History Review*

Please check the appropriate response below.

	Yes	No	Comments/Explanation
Cancer			
Diabetes			
Osteoporosis			
Osteopenia			
Dizziness/Lightheadedness			
Dyspnea (shortness of breath)			
Heart Disease			
High Blood Pressure			
Pacemaker			
History of Lung Disease			
History of Smoking			
Dysuria (painful urination)			
Urinary Frequency Changes			
Bowel Dysfunction			
Malaise (fatigue)			
Nausea/Vomiting			
Pregnant			
Recent Fever/Chills/Sweats			
History of Substance Abuse			
Unexplained Weight Loss			
History of Fainting			
Weakness			
Increased Pain at Night			
Numbness			
Metal Implants			

Please list any medications you are currently taking:

\_\_\_\_\_

Please list any surgeries you may have had and approximate dates:

\_\_\_\_\_

Do you smoke? \_\_\_\_\_ If so, how much? \_\_\_\_\_

How much caffeine do you consume daily (includes soft drinks, coffee, tea, chocolate):

Your Physician(s): \_\_\_\_\_

\_\_\_\_\_

Barley Mill Rehabilitation  
Greg Rybicki, PT  
3604 Lancaster Pike  
Wilmington, DE 19805

**AUTHORIZATION TO PAY INSURANCE BENEFITS**

I hereby authorize payment directly to Barley Mill Rehabilitation for all benefits payable to me under the terms of my insurance policy with respect to treatment/services provided to me or my dependents and for any subsequent treatment/services.

I understand that I am financially responsible for any balance or charges not covered by my insurance.

I also authorize payment from my attorney, if applicable, directly to Barley Mill Rehabilitation of any amounts resulting from any court action or settlement relating to this injury or condition.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_  
(If Minor)

**FOR MEDICARE PATIENTS ONLY**

I request that payment to authorized Medicare benefits be made to Barley Mill Rehabilitation/Greg Rybicki, PT for any services furnished to me by his office. I authorize any holder of information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Date \_\_\_\_\_ Signature \_\_\_\_\_

## BARLEY MILL REHABILITATION

### SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following is a summary of the Notice of Privacy Practices. A full description of these Practices is available upon request. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

We are required, by law, to: make sure that health information about you is kept private; give you notice of our legal duties and privacy practices with respect to health information about you; and follow the terms of the notice that is currently in effect.

#### **HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU.**

The following examples describe some of the ways that we may use and disclose health information. **Treatment** – For example, we may disclose information about you to doctors, nurses, or other personnel who are involved in taking care of you. **Payment** – For example, to receive payment for services provided to you, we may disclose information to insurance companies or other third party payers. **Health Care Operations** – For example, we may use your medical information to evaluate our services, contact you at any phone number or address you have provided to us to remind you of an appointment or other health care matters or to obtain payment for our services. We may disclose medical information about you to family members who are involved in your care or payment for that care. We will also provide health information as required by federal, state, or local law. Other uses of your medical information will be made only with your written authorization. You may cancel an authorization at any time by notifying our Designee in writing.

#### **PATIENT'S INDIVIDUAL RIGHTS**

You have the following rights: Right to privacy notice; Right to inspect and copy your medical records; Right to request an amendment to your medical record; Right to request an accounting of any disclosures of your health information; Right to request restrictions or limitations on the health information we disclose; and Right to request confidential communications.

#### **CONCERNS AND COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint in writing with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact Greg Rybicki, Privacy

Official, Telephone 302-995-6095. Mailing address: Barley Mill Rehabilitation, 3604 Lancaster Pike, Wilmington, DE 19805.

**ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE**

We will request that you sign a separate form acknowledging that you have received a copy of this notice. This acknowledgement will be filed with your records.

BARLEY MILL REHABILITATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, have received or been offered a copy of this office's Notice of Privacy Practices.

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

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FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained due to:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- Other (Please Explain)

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Staff Signature: \_\_\_\_\_