

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: _____

FOR OFFICE USE ONLY

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)

Staff Signature: _____