

Injury Information Form

M.V.A. _____

Workers Compensation _____

Name: _____

Date of Birth: _____ SS# _____

Date of Accident/Injury _____

Employer: _____

Are you Currently Working? Yes _____ No _____ Last Day of Work _____

Workers Comp. Carrier/P.I.P. _____

Address: _____

Phone Number: _____

Adjuster: _____

Claim Number: _____

Medical Insurance: _____

Policy Number: _____ Group # _____

Attorney: _____

Address: _____

Phone: _____

If benefits are exhausted, we will bill your medical insurance for payment **IF** all referrals and authorizations have been approved prior to visits. Otherwise payment is your responsibility.

Signature

Date: _____

Notice of Privacy Practices:

GOLD MEDAL PHYSICAL THERAPY, LLC.

9649 Belair Road, Suite 301, Perry Hall, MD 21236

Dear Parent, Guardian or Patient,

“This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.”

Due to recent changes in State and Federal regulations governing privacy practices and in order to update our records, please complete the attached registration for you or your family. Please provide the current information regarding your telephone numbers (home and work) and home address. This will allow us to make the correct contact when trying to reach you.

The practice has implemented policies and procedures so that the confidentiality of your personal and/or medical information remains confidential. Your Physician(s) as well as all other employees working in the practice will keep any information related to you or your child (medical and/or non-medical) in a confidential manner.

So that we may provide you or your child with appropriate medical care, for general practice operations and/or for the purpose of obtaining payment, we will, at our discretion provide information regarding the treatment you or your child received in this practice, the charges for this treatment and related information regarding the treatment and charges to other health related entities such as:

- Physician/Non-Physician Providers (i.e. Physical Therapist, Nutritional Counselors, etc) who work outside of this practice.
- Medical Facilities (i.e. hospitals and outpatient centers)
- Laboratories for the purposes of running medical tests
- Other health care providers such as pharmacies, durable medical equipment suppliers, and ambulance services
- School Health Departments
- Insurance companies (or third party administrators) for the purpose of obtaining payments, reviewing medical necessity and/or general case management
- State or Federal agencies that require the submission of specific health related information

This information will be submitted by means of the U.S. Postal Service, fax, Internet, voicemail and/or personal communications.

We may need to contact you, by telephone, to discuss your appointments, test results, treatment, referrals, account balance and/or return your telephone call. We will first attempt to contact you at home; however, if you are not available and you provide us with your work telephone number, we may attempt to contact you at work. If you are not available, we may leave a message for you to either call the office or we may leave information to remind you of an appointment time.

In the event that you do not pay all of your charges at the time of your visit, we will mail a statement to your home. Also, depending upon your situation, we may mail other correspondences to your home noting that we are trying to contact you regarding a scheduled appointment, to schedule an appointment, to mail test result information or other medical and/or non-medical information that you may have requested or information regarding your account in order to collect a debt.

We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your co-insurance and co-pay requirement.

When you arrive at our practice for your appointment, we will ask you to sign in. If you would like information sent to another physician or medical facility, you must authorize the release of this information, in writing (we will provide the necessary form to complete) upon registration. Also, you must provide written authorization for the release of information to your life, disability, or future health insurance carrier.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. This may not include psychotherapy notes.

You must submit your request in writing to the Practice Manager in order to inspect and/or obtain a copy of your PHI. Our practice charges a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however you may request a review of our denial. Another health care professional chosen by us will conduct reviews.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by providing a written request to the practice at any time.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set or as long as we maintain this information. In certain cases, for example if we think the information is correct, or was not created by our practice, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Practice Manager to determine if you have questions about amending your medical record. To file an amendment, your request must be in writing and must be submitted to the Practice Manager.

When necessary, these policies will be modified to ensure compliance with the practice operations and with State and Federal privacy regulations.

If you have any questions or concerns with the policies and/or procedures noted above, please contact the Practice Manager to discuss them. We trust that you are comfortable with our efforts to maintain confidentiality of the information related to you or your child’s medical care.

Sincerely,

Gold Medal Physical Therapy, LLC.