SOMERTON PHYSICAL THERAPY
MARK J. ROSEN, P.T., P.C.

Patient Information

NAME_____AGE_____BIRTHDATE___/___/___

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK_____CELL_____

SOCIAL SECURITY #_____SEX_____MARITAL STATUS: S M W D

EMERGENCY CONTACT_____RELATIONSHIP_____

EMAIL_____ Emergency Contact Phone Number: _____

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____

REFERRING DOCTOR_____

FAMILY DOCTOR_____

MEDICAL INSURANCE_____PHONE NUMBER_____

IDENTIFICATION NUMBER_____GROUP NUMBER_____

DATE OF INJURY/ACCIDENT_____ _____

AUTO INSURANCE NAME_____

ADDRESS_____

CLAIM NUMBER_____ADJUSTER_____

ADJUSTER PHONE NUMBER_____

ATTORNEY NAME_____

ADDRESS_____

PHONE NUMER_____

WORKER'S COMP CARRIER_____

ADDRESS_____

CLAIM NUMBER_____ADJUSTER_____

PHONE NUMBER_____

ADDITIONAL INFO:_____

_____

_____

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due. I also authorize the release of medical records or reports needed for treatment. I permit a copy of this release to be used in place of the original.

Signature:_____Date:_____
(Signature of insured or authorized person, patient or parent if minor)

<u>If you are a Medicare patient</u> ....PLEASE TAKE A MOMENT AND ANSWER THE QUESTIONS BELOW:

1. Did you sustain these injuries at work? _____yes _____no

2. Are any of your injuries accident related? _____yes _____no

3. If you are on Medicare, are you currently employed? _____yes _____no

4. If you are on Medicare, does your spouse have insurance _____yes _____no

5. Are you covered under your spouses' insurance? _____yes _____no

6. Are you covered under any Union Insurance plans _____yes _____no

7. Besides Medicare and a Medicare Supplemental Insurance, are you covered under any other insurance?
_____yes _____no

Please note that Medicare is a federal insurance program. There are many rules that we must follow to be in compliance with the Medicare guidelines. We will submit billing to Medicare using the above answers to the questions as our guideline.

SOMERTON PHYSICAL THERAPY AND REHABILITATION
MARK J. ROSEN, P.T., P.C.
Somerton Medical Building • Suite 100
12000 Bustleton Avenue
Philadelphia, PA 19116-2151
215-677-8870
Fax 215-673-9825

Authorization to Use or Disclose Health Information

Patient Name:_____Phone #:_____

Date of Birth:_____S.S. #:_____Medical Record #:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual(s) or organization(s) are authorized to make disclosure:_____
   _____
3. The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated.)
   Date(s) of Service:_____

__FaceSheet/Registration Sheet/Referral Sheet	__Operative Report
__Discharge Summary	__Implant Report
__ER Record	__Pathology Report
__H&P	__Medication List
__Consults	__Behavior Health Information
__Progress Notes	__Substance Abuse Information
__Discharge Instructions	__Human Immunodeficiency Virus Information
__Lab Results	__Entire Report
__Radiology Results	__Home Health Records
__EKG/Cardiology Testing Results	__OTHER, please specify,_____

4. I understand that if my authorization includes Behavioral Health Information, substance abuse may include: (i)information concerning whether an individual has been the subject of a human immunodeficiency virus (HIV) related test, has HIV, an HIV related illness, acquired immunodeficiency virus (AIDS), and/or including information pertaining to the individual. (Section 7100.133) (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse. (Pennsylvania Drug and Alcohol abuse control act of 1972 – act 143 section 7(e); (iii) behavioral health information services. (Mental Health Procedures act 1976 section 6100.3.39)
5. The information identified above may be used by or disclosed to the following individual or organization(s):
   Name: **Mark J Rosen, P.T., P.C.**
   Address: **12000 Bustleton Ave, Suite 100 Philadelphia, PA 19116**
6. This information for which I'm authorizing disclosure will be used for the following purpose:
   __Sharing with other health care providers as needed __Other (please describe):_____
7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right contest a claim under my policy.
8. Unless I specify differently, this authorization will expire six months from the date signed below:_____
   _____
9. I understand that once the above information is disclosed it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date
If signed by legal representative, relationship to patient:_____

_____ _____
Signature of witness Date

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We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name_____Signature_____Date_____

SOMERTON PHYSICAL THERAPY
MARK J. ROSEN, P.T.
12000 Bustleton Avenue, Suite 100
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PRIMARY COMPLAINT:_____

If Surgery Related/ Please give date of the last surgery:_____

CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered._____(Sign)

Do you have any barriers to learning: YES/NO If "Yes", please list?_____

Gender: M / F Age:_____ Smoker: YES/NO Pregnant: YES/NO
Do you exercise at least 3 days per week? YES/NO

Past Surgical History (list and date):_____

Current Medications:_____

Past Medical History: Please circle each condition that you have been told you have (or had):

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/chest pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Lung Disease	
Allergies/Asthma	Sexually Transmitted Disease			

Have you had a recent illness YES/NO (explain if yes)?_____
Do you take blood thinners? YES/NO Are you allergic to latex? YES/NO
Other:_____

Currently I am experiencing (circle all that apply):

Unexplained weight loss	Numbness or tingling	Fever/chills/sweats	Poor balance (falls)
Depression	Shortness of breath	Changes in appetite	Difficulty swallowing
Changes in bowel or bladder function		Dizziness	Headaches
		Nausea/vomiting	Increased pain at night

How are you able to sleep at night? ☐Fine ☐Moderate Difficulty ☐Only with medication

During the past month, have you often been bothered by feeling down, depressed or hopeless? YES/NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES/NO

What date (approximately) did your present pain start?_____

How (gradually, suddenly, injury)?_____

My symptoms are currently (circle one): Getting better / About the same / Getting worse

What treatments have you received for this problem so far?_____

What makes your symptoms better?_____

What makes your symptoms worse?_____

Have you had an x-ray, MRI, or other imaging study for this problem? YES/NO

NAME: DATE:

SOCIAL SECURITY #: PHONE NUMBER(S):

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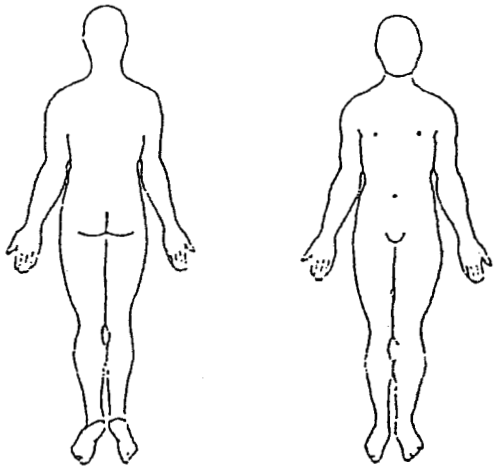
Mark J. Rosen, P.T.
Lawrence C. Bruno, M.

Body Chart:
Please mark the areas where you feel pain on the chart to the right.



For the Therapist
+ / - Cough/Sneeze
+ / - Saddle
+ / -
+ / - Numb/Tingle

On the scales below, please circle the number which best represents the average level of pain you have experienced over the last 48 hours:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

Please circle the number below which best represents your overall average level of function:

Cannot do anything	0	1	2	3	4	5	6	7	8	9	10	Able to do everything

What are your personal goals for therapy at this time? _____

_____

_____

Aggravating Factors: Identify up to 3 important activities that you are able to do or are having difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____

Below for the Therapist
Rating _____
Rating _____
Rating _____
AVG _____

Therapist Use

Medication List

Patient Name:_____

(Please list all medications that you are currently taking)

Name of Medication	Dosage	How often taken