SWEENEY REHAB & FITNESS

PATIENT INFORMATION

PATIENT NAME: ________________________ **PHYSICIAN:** ________________________

ADDRESS: ________________________ **PHYSICIAN UPIN & NPI#:** ________________

CITY: ________________________ **STATE:** __________ **ZIP:** __________

HOME PHONE: (____)______________ **WORK:** (____)__________ **CELL:** (____)__________

E-MAIL ADDRESS ________________________

EMPLOYER: ________________________ **DOB:** ______________ **AGE:** ________

ADDRESS: ________________________ **SOCIAL SECURITY #:** ________________

________________________ **SEX:** **M** **F**

INSURANCE TYPE: **PRIVATE** **MEDICARE** **MANAGED CARE** **AUTO** **WORKERS COMP** **SELF-PAY**
(Circle One)

INSURANCE: ________________________ **INSURED:** ________________________

ADDRESS: ________________________ **RELATIONSHIP:** ________________________

________________________ **DATE OF BIRTH:** ________________________

________________________ **POLICY #:** ________________________

SECONDARY INS: ________________________ **GROUP:** ________________________

ADDRESS: ________________________ **CLAIM #:** ________________________

________________________ **DATE OF INJURY/ACCIDENT:** ________________

AUTHORIZATION #: ________________________ **ADJUSTOR:** ________________________

DIAGNOSIS CODES

1. ________ ________________________

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2. ________ ________________________

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3. ________ ________________________

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4. ________ ________________________

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PRIVACY NOTICE

__________ (Initials) **I have received the "Notice of Privacy Policies of C.P.T.S., L.L.C., dba Sweeney Rehab & Fitness.**

RELEASE & ASSIGNMENT

__________ (Initials) **I authorize release of any information necessary to process my insurance claims & assign & request payment directly to C.P.T.S., L.L.C., dba Sweeney Rehab & Fitness.**

X ________________________________

Patient Signature **Date**

Please check any of the following that apply to you and explain below:

Diabetes	Joint replacement	History of Cancer
Cardiac problems/surgery	Skin sensitivities	Surgery
High/low blood pressure	Allergies	Other (please specify)

Explain: ____

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MEDICARE RELEASE

Name of Beneficiary: ____

Health Insurance Claim#: ____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service."

Beneficiary Signature:_____________________________________ Date: ____________________

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MEDIGAP RELEASE

Name of Beneficiary: _______________________________________

Health Insurance Claim #:____________________________________

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and/or supplier for any services furnished to me by the provider of service and/or supplier. I authorize any holder of Medicare information about me to release to (Medigap Insurer) ________________ ________________________ any information about me to determine these benefits payable for related services."

Beneficiary Signature: ___________________________________ Date:______________________

PRIVACY NOTICE

Physicians have always protected the confidentiality of health information by sealing records in file cabinets and refusing to reveal your medical information. Today **State** and **Federal Laws** also attempt to ensure confidentiality of this sensitive information.

The **Federal Government** recently published regulations designed to protect the privacy of your health information. This **Privacy Rule** protects health information that is maintained by physicians, hospitals, and other health care providers and health care plans.

This new regulation protects virtually all patients. Every time you see a physician, are admitted to the hospital, receive a prescription, or send a claim to a health plan, your physician and the hospital or other health care provider will need to consider the Privacy Rule. All health information including paper records, oral communications, and electronic formats are protected by the Privacy Rule.

Precautions are also taken in this office to safeguard your health information by training our employees and employing computer security measures. Please feel free to ask our **Privacy Officer, Kevin L. Sweeney, P.T.,** about how your health information is protected in our office.

Please let us know if you have any questions about our privacy practices. You may contact our **Privacy Officer, Kevin L. Sweeney, P.T.** at (724) 437-0250 or discuss any questions you may have with the treating therapist.