WILDERMAN PHYSICAL THERAPY, LLC
PATIENT INFORMATION

Name:____ Today's Date:________________
Last First Middle Initial

Address:____
Street

____
City State Zip

Home phone: ( )__________________ Cell phone: ( )_________________

Email:______________________________ Social Security #: ______-____-_______

Marital status: ___Single ____Married ____Divorced _____Other

Date of Birth:__________ Age:___ Patient Sex: ___Male ___Female

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Occupation:____

Status: ____Employed ___Retired ___Student ___Not working

Employer name:______________________________ Phone #: ( )_____________

Employer Address:____
Street City State Zip

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Referred By:______________________ Relation to Referral Source:_____________________

Primary Care Physician:________________________ Referring Physician:__________________

Date of Injury:________ Is this injury job related? __Yes ___No Auto Accident? __Yes ___No

How did you first hear about Wilderman Physical Therapy,LLC ?

____

In case of emergency, contact:________________Relationship:_________ Phone: ( )_______

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I hereby certify that all information is true to the best of my knowledge, and I am responsible for all charges incurred for these services.

Patient/Parent/gGuardian signature:_________________________________Date:_____________

WILDERMAN PHYSICAL THERAPY, LLC
MEDICAL HISTORY QUESTIONNAIRE

Patient name:_______________________________________ Date:______________

Date of Birth/Age:__________/______ Are you presently working? Yes___No___

Referring Physician (if applicable):______________ Family Physician:_______________
Date of injury/onset:____________ Have you ever had these symptoms before? Yes___No___
Check all that apply to your symptoms:
_____Work related injury _____Recurrence of previous injury _____Motor vehicle accident
_____Injury related to lifting _____Athletic/recreational injury _____Injury related to falling
_____Cause unknown _____Other(please specify):______________________________

Date last worked to this injury:___________ Date returned to work after this injury_________

On a scale from 0 (no pain) to 10 (most severe pain) rate your pain level:
Best/Lowest_____/10 Right Now______/10 Worst/most_____/10

My pain can be described as (check all that apply):___Constant ___Intermittent ___Sharp ___Dull
___Aching ___Stabbing ___Numbness ___Pins/Needles

Have you had any of the following Medical or Rehabilitative Care for this injury/episode?
If yes, when?_________________________

	YES	NO		YES	NO		YES	NO
Chiropractor	___	___	Neurologist	___	___	X-Rays	___	___
General practitioner	___	___	Orthopaedist	___	___	MRI	___	___
Physical Therapy	___	___	Podiatrist	___	___	CT Scan	___	___
Occupational Therapy	___	___	ER Care	___	___	Myelogram	___	___
Home Health Service	___	___	Massage Therapy	___	___	EMG/NCV	___	___

Have you ever had surgery related to this condition? ___YES ___NO
Do you have any of the following?

	YES	NO		YES	NO		YES	NO
Diabetes	___	___	Allergies	___	___	Seizures	___	___
Chest pain/Angina	___	___	Hypothyroid	___	___	Osteoporosis	___	___
High Blood Pressure	___	___	Hyperthyroid	___	___	Hernia	___	___
Heart Attack	___	___	Stroke (CVA)/TIA	___	___	Headaches	___	___
Heart Palpitations	___	___	Liver/gallbladder problems	___	___	Recent Fractures	___	___
Heart Disease	___	___	Kidney problems	___	___	Surgeries	___	___
Blood clot/Emboli	___	___	Bowel/bladder abnormalities	___	___	Metal Implants	___	___
Pacemaker	___	___	Sleeping difficulty	___	___	Urine leakage	___	___
Dizziness/Fainting	___	___	Cancer	___	___	Women Only:		
Joint Replacement	___	___	Infectious Diseases	___	___	Pregnant	___	___
Rheumatoid Arthritis	___	___	Hearing/vision difficulty	___	___	Endometriosis	___	__
Osteoarthritis	___	___	Asthma/Breathing difficulties	___	___	Pelvic Inflam. Disease	___	___
Multiple Sclerosis	___	___	Weight Loss	___	___	Irreg. Menstrual Cycle	___	___
Parkinson’s Disease	___	___	Energy Loss	___	___	Complicated pregnancies	__	__

If YES to any of the above, please briefly explain and give approximate dates:

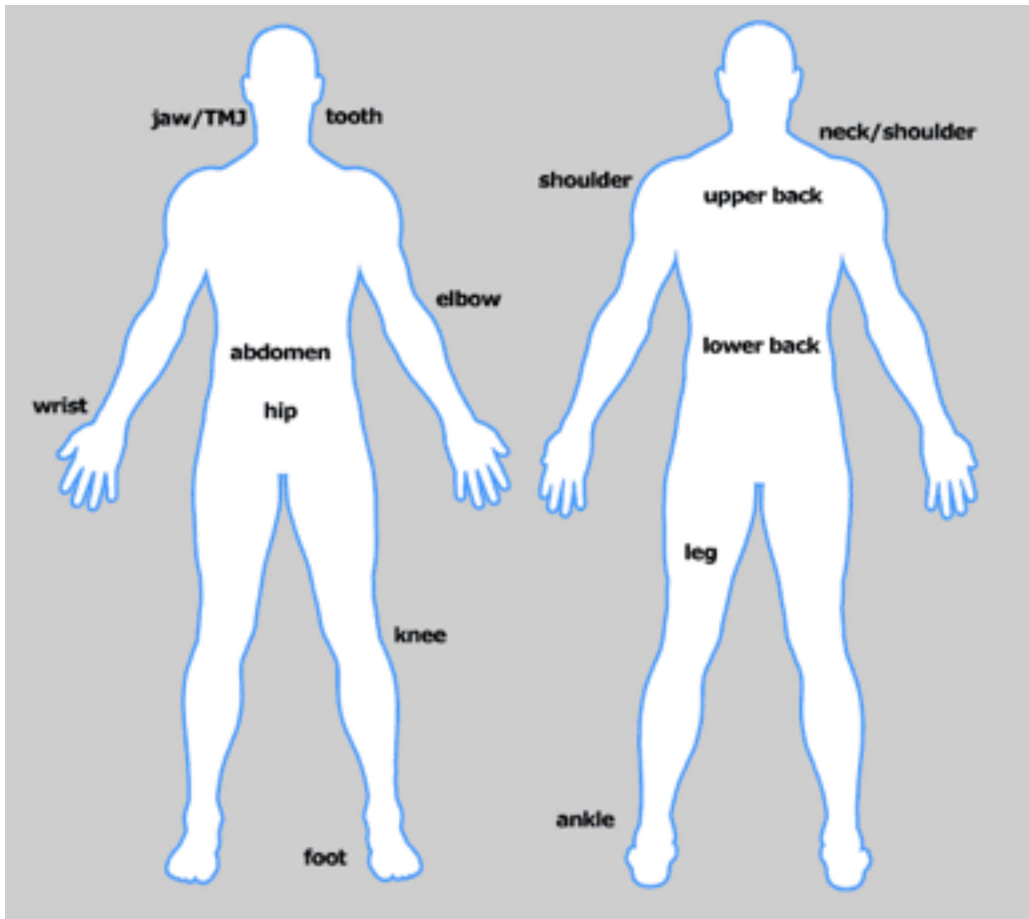
____
____
____
____

Are you currently taking medication? ___YES ___NO
(If YES, please list medication and for what condition):

____
____
____
____

PLEASE COLOR YOUR AREA OF PAIN ON THE BODY DIAGRAM BELOW

FRONT **BACK**



What goals would you like to achieve through Physical Therapy?

____
____
____
____

I certify that the information provided on my Medical History has been provided as accurately as possible.

Patient/Guardian Signature_______________________________Date:_____________

WILDERMAN PHYSICAL THERAPY, LLC

POLICIES

We are **dedicated** to providing **highly individualized manual and therapeutic/functional exercise care** for clients with **sports or orthopaedic injuries/pain**. Your plan of care is achieved through the professional assessment of your physical therapist and is based on your specific needs. **Please read carefully the following policies and sign below.**

1. **Insurance:** In order to achieve the best possible results for our clients, WILDERMAN PHYSICAL THERAPY, LLC does not bill third parties for payment. Payment is expected when services are rendered. Client is fully responsible for knowledge of his/her own insurance benefits and reimbursement policies. WILDERMAN PHYSICAL THERAPY, LLC will make being reimbursed by your insurance provider as easy as possible providing all necessary records and documentation as needed.

2. **Automobile Accidents:** We do not bill auto insurance companies nor do we accept assignments on any automobile accident. We do not wait for settlement from attorneys or wait for settlement from any automobile carriers. Reimbursement for care can be obtained in the same way that clients are reimbursed from a health insurance carrier.

3. **Medicare:** We are not Medicare providers and cannot bill Medicare for you. At this time we cannot accept clients who intend to bill Medicare.

4. **Durable Medical Equipment (DME) and Supplies:** Some DME and supplies are not reimbursable by insurance companies and must be paid for prior to ordering.

5. **Payment:** Payment is **expected when services are rendered (each visit).** We accept Visa, MasterCard, American Express, Discover, JCB, HSA/FSA, check, and cash. We expect accounts to be paid in full within 30 days from the last day of treatment.

6. **Late Charges/Returns Checks:** Any account that remains open beyond 30 days from last date of treatment will be subject to a **$10 fee** for each month that the account is not paid in full. There is a **$35 fee** for all returned checks.

7. **Cancelled/Missed Appointments:** If a client is more than 15 minutes late for an appointment, **WILDERMAN PHYSICAL THERAPY, LLC** reserves the right to cancel or reschedule the treatment. Late arrivals are subject to the full fee for the session. **We require 24 hour notice for cancellations. Appointments that are cancelled with less than 24 hours notice or no-show appointments are subject to the full charge the scheduled appointment,** which is not reimbursable by insurance providers. **Payment information on file will be used to make payments for missed or late cancelled appointments.**

8. **Right to Triage: WILDERMAN PHYSICAL THERAPY, LLC** will see each client at their greatest convenience. However, we reserve the right to triage clients on emergency cases.

9. **Fees:** We reserve the right to alter the fee schedule without notice. Please see our latest fee schedule for Initial Evaluations and subsequent physical therapy sessions consisting of 30 or 60 minutes. After the Initial Evaluation, subsequent Physical Therapy sessions are billed in 15-minute increments and are typically one (1) hour.

10. **Our pledge regarding medical information:** We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at **WILDERMAN PHYSICAL THERAPY, LLC.** We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by **WILDERMAN PHYSICAL THERAPY, LLC.** We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you (see Notice of Privacy Practices).

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I have read the above policies and understand that payment is due when services are rendered. I agree to accept full financial responsibility for medical expenses incurred at **WILDERMAN PHYSICAL THERAPY, LLC.**

If a patient is under 18 years of age, and a parent/guardian is not able to attend sessions of Physical Therapy with the minor, the parent's/guardian's signature for authorization allows **WILDERMAN PHYSICAL THERAPY, LLC** TO commence Physical Therapy treatments with the client who is a minor. The parent/guardian is also accepting full financial responsibility for the treatment.

Client Signature:______________________________________Date:__________________

Parent/Guardian Signature:_____________________________ Date:__________________
(If client is under 18 years of age)

WILDERMAN PHYSICAL THERAPY, LLC

Consent For Physical Therapy Evaluation and Treatment

I,_____________________________, consent to receiving physical therapy evaluation and treatment. You are an important partner in your health care decisions and play an active role in the outcome of your medical care. Thus, it is important that you are informed about benefits, risks, evaluations, and decisions related to your care while being seen in this office. If you have questions, symptoms, or problems related to your care it is your responsibility to notify your physical therapist and consult with your primary care physician as necessary. By signing below, I agree to be treated by Wilderman Physical Therapy, LLC, knowing there may be potential risks along with benefits and I am willing to be an active participant in my own care.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examination, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information. By signing below, I agree to consent to treatment and agree that I have been informed about this privacy practice and my protected health information and how to obtain a personal copy of this form and privacy policy.

Signature:___________________________________Date:_________________

Wilderman Physical Therapy, LLC
3101 Limestone Rd., Ste. B
Wilmington, DE 19808
Ph:(302)691-9055
www.wildermanpt.com

Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health insurance and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operation.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review.

- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the healthy and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends or any person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

- The right to request an amendment to your PROTECTED HEALTH INFORMATION.

- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

- The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

- We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will

be posted on the effective date and you may request a written copy of the Revised Notice from this office.

- Your have the right to a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
Main Line (800) 368-1019
FAX (215) 861-4431
TDD (800) 537-7697