CUMBERLAND PHYSICAL THERAPY & REHAB
CUMBERLAND CENTER FOR FALL PREVENTION

Dave Escobar, PT, MS, OCS
115 Trade Park Drive, Suite 1 Somerset, KY 42503
Phone: 606-678-5807 Fax: 606-679-1791

(Please print)

Patient Name:_____ Male / Female
First Middle Last

Social Security Number:_____ Birthday:_____/_____/_____ Age:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Cell #: (_____)_____

Circle One: Married Single Widowed **Email address:**_____

Patient's Workplace (Patient's Guardian if minor) _____

Phone #:(_____)_____

Primary Languages: English Spanish Other: _____
Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race: White/Caucasian American Indian Asian African American Other:

***EMERGENCY CONTACTS: You must list at least 2 contacts (CAN NOT be living with you)**

(1) Name: _____

Phone #: _____ Relationship to Patient: _____

(2) Name: _____

Phone #: _____ Relationship to Patient: _____

(Complete only if you are insured under your guardians/spouses insurance plan)

Name: _____ Birthday:_____/_____/_____

Social Security Number:_____ Relation to patient _____

REFERRING PHYSICIAN

Family Physician's Name: _____ Phone #: _____

Referring Physician's Name: _____ Phone #: _____

HOW WERE YOU REFERRED TO US? –OR- HOW DID YOU HEAR ABOUT US?
Check all that apply:
_____Newspaper _____Magazine _____Radio _____Yellow Pages
_____Internet _____Facebook/Twitter _____Insurance Company
_____Family or Friend (please enter name):_____
_____Physician (please enter name):_____
_____Other_____

MEDICAL HISTORY

Do you have or have you been treated for:

_____Stroke	_____Heart Attack	_____High Blood Pressure
_____Phlebitis	_____Vascular Disease	_____A Heart Condition
_____Diabetes	_____Poor Circulation	_____Hepatitis
_____Liver Disease	_____Gout	_____Arthritis
_____Epilepsy	_____Kidney Disease	_____Thyroid Problem
_____Cancer	_____Stomach Ulcer	_____Tuberculosis

_____OTHER:_____

Allergies: Please mark any of the following if you have or have had a reaction to:

_____Penicillin	_____Other antibiotics (list below
_____Morphine	_____Codeine
_____Demerol	_____Other narcotics (list below)
_____Novocaine	_____Other anesthetics (list below)
_____Aspirin	_____Empirin, Tylenol
_____Advil, Aleve, or Motrin	_____Other pain remedies (list below)
_____Sulfa Drugs	_____Adhesive tape
_____Shrimp, Iodine, or Merthiolate	_____Any other drugs or medication

ASSIGNMENT OF INSURANCE BENEFITS

I/We hereby authorize payment of insurance benefits directly to Cumberland Foot and Ankle Center. These payments will not exceed my / our indebtedness for services rendered. I /we understand that personal information about me/us will be needed by the Doctor, and my insurance plan to determine and communicate what services or benefits are covered by my insurance plan, and to submit and process a claim for payment on services rendered and for the doctor to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I/we give the doctor my insurance plan, the Centers for Medicare and Medicaid Services (CMS), their agents, and and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing, and collection information. This assignment shall remain in effect until cancelled in writing by Cumberland Foot and Ankle Center. I/We agree to promptly pay any remaining balance due on all professional and medical services. I further agree that Cumberland Foot and Ankle Center is authorized to act in my behalf in the endorsement of benefit checks made payable to me and/or Cumberland Foot and Ankle Center. A photocopy of this agreement, or an electronic facsimile thereof, shall be considered as effective as the original.

_____ _____

Patient Signature or Authorized Agent **Date**

ACKNOWLEDGEMENT OF THE NOTICE OR PRIVACY PRACTICES

I hereby acknowledge that I have been made aware that the Cumberland Foot and Ankle Center Privacy Practices privacy policy is hanging in the patient waiting room and that is visible for my viewing. A paper copy is available at my request. The Privacy Policy sets forth the way in which my Protected Health Information may be used or disclosed and outlines my right with respect to such information. I also acknowledge that I have been allowed to ask questions. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____

Patient Signature or Authorized Agent **Date**

AUTHORIZATION FOR TREATMENT, FINANCIAL AGREEMENT, & INFORMATION RELEASE

The Responsible Parties whose signatures appear below agrees as follows:

The Doctor(s), Associate Doctor(s), Nurse Practitioner, and staff of Cumberland Foot and Ankle Center, named on this form and hereafter referred to as DOCTOR, are authorized to medically treat the patient named on this form.

DOCTOR is authorized to collect, use and exchange *individually identifiable health information (IIHI)* consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patient's other health care providers, seek payment and carry out necessary business functions. A patient may request to see IIHI pertaining to themselves, request copies, ask for corrections or amendments to the IIHI and request in writing restrictions on its' future use. DOCTOR is not obliged to honor all such requests.

The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until the DOCTOR receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

Not all services and/or fees are covered or paid for by the Responsible Parties' health PLAN. Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill. All proceeds from the PLAN are assigned to DOCTOR when applicable. Payments to DOCTOR may not be withheld, delayed or excused for any reason; including the outcome of claims, the financial insolvency of the PLAN and/or their contracted intermediaries & medical groups. Responsible parties are strongly advised to monitor, and communicate with the PLAN to ensure that DOCTOR's claims are paid promptly, since they, as Responsible Parties, are ultimately financially responsible for all amounts owed to DOCTOR.

The Responsible Parties acknowledge receipt of DOCTOR's Office Policy that include the terms of this Financial Agreement, Authorization for Treatment & Information Release. This form together with DOCTOR's Office Policy contain the entire and only agreements between the parties. There are no other agreements, promises, representations or warranties, expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument in writing signed by the parties hereto.

I give permission for Cumberland Foot and Ankle Center to leave messages at my residence regarding appointments, x-rays, labs, etc. **Yes **No**

**Please list family members that we may share your medical information with:

_____

_____

Agreed to and accepted by the Responsible Parties:

Signature:_____ **Date:**_____