PRO
MEDICAL REHABILITATION, INC.

DAVID LYNCH, M.D.

specialized in
PHYSICAL MEDICINE & REHABILITATION
AND ELECTRODIAGNOSTIC MEDICINE

PATIENT INFORMATION

PLEASE FILL OUT ALL QUESTIONS

PATIENT NAME: _____ DATE OF BIRTH: _____ SS#_____

ADDRESS: _____

CITY/STATE: _____ ZIP CODE _____ SEX: M or F MARITAL STATUS: _____

HOME PHONE_____ WORK: _____ CELL:_____

EMPLOYED_____ NAME OF EMPLOYER_____ STUDENT_____ UNEMPLOYED_____

ADDRESS_____ CITY_____ STATE_____ REFERRING DR._____

EMERGENCY CONTACT: _____ PHONE:_____ RELATIONSHIP TO PT: _____

INSURANCE INFORMATION

Please fill out all information even if this is for worker's comp or auto accident

PRIMARY INS._____ POLICY # _____ SS# INS. HOLDER_____

NAME OF INS. HOLDER_____ PT RELATIONSHIP TO INS. HOLDER_____ INS. HOLDER DOB: _____

WORK, AUTO, or other INJURY INFORMATION (check one)

WORKERS COMP _____ STATE FILED_____ AUTO _____ OTHER _____ DATE OF INJURY_____

NAME OF WC COMPANY_____ ADDRESS:_____ CITY/STATE:_____

PHONE: _____ CLAIM OR POLICY #:_____ IF IN LITIGATION, ATTORNEY NAME:_____

ASSIGNMENT AND RELEASE

I the undersigned have insurance coverage with_____ and assign directly to Pro Medical Rehab all medical benefits. If, any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all necessary information to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Pro Medical Rehab for services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature on the HCFA-1500 form, or elsewhere on other approved claim forms electronically submitted claims authorized releasing to the insurer or agency shown.

_____ _____

Beneficiary Signature Date

460 Mylan Park Lane, Morgantown, WV 26501 • phone (304) 983-7766 • fax (304) 983-7768

PRO Medical
Rehabilitation

'Team up with Pro for better healthcare!'

I understand I am being seen for an Independent Medical Evaluation ONLY and no treatment is to be undertaken. No physician/patient relationship will be established. This evaluation should not be construed as a comprehensive physical examination for any general health purpose. I understand I may stop the examination at any point I wish not to proceed any further.

Sign: _____

Date: _____

460 Mylan Park Lane • Morgantown, WV 26501 • Ph. 304/983-7766 • Fax: 304/983-7768
www.ProMedicalHealthCare.com

PRO Medical
Rehabilitation

'Team up with Pro for better healthcare!'

AUTHORIZATION OF NON-PAYMENT WAIVER

I understand that in the event that my insurance does not cover any procedures or labs done within Pro Medical Rehab, I will be responsible for payment.

If I am covered by workers' compensation any labs or testing done will have to be approved by my claims adjuster, at which time if denied that I will be responsible for payment in full on the next visit to the medical office.

I also understand that if I am a private pay patient, that I will be responsible for any and all office visits, procedures and/or testing. Without payment being made I am aware that I may not be rescheduled with the physician for any return visits, treatments, or procedures, etc.

Patient Signature:_____Date:_____

460 Mylan Park Lane • Morgantown, WV 26501 • Ph. 304/983-7766 • Fax: 304/983-7768
www.ProMedicalHealthCare.com

PRO Medical
Rehabilitation

'Team up with Pro for better healthcare!'

Notice of Privacy Practices
Pro Medical Rehabilitation, Inc.

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**

Uses and Disclosures:

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, form other sources of coverage, such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Pro Medical Rehabilitation, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information:

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that we think you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights:

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to our protected health information
- The right to receive an accounting of how and to whom our protected health information has been disclosed.
- The right to receive a printed copy of this notice.

PRO Medical
Rehabilitation

'Team up with Pro for better healthcare!'

Pro Medical Rehabilitation, Inc. Duties:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Rights to Revise Privacy Practices:
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information:
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the HIPAA Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints:
If you would like to submit a comment or complaint about our practices, you can do so by sending a letter outlining your concern to:

Privacy Officer
Pro Medical Rehabilitation, Inc.
460 Mylan Park Lane
Morgantown, WV 26501

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date:
This notice is effective on or after April 14, 2003.

I have received and been given the opportunity to review the "Pro Medical Rehab, Inc. Privacy Notice".

Signed:_____ Date:_____