Confidential Information

Name	Home Phone	Work Phone	Cell Phone
Address	Date of Birth	Age	☐ Male ☐ Female
	☐ Single ☐ Married ☐ Widowed ☐ Divorced		
City/State/Zip	Social Security Number		

Primary Care Physician		Occupation
Address		Employer
		Address
City/State/Zip		City/State/Zip
Phone	Fax	Phone

✔ PRIMARY INSURANCE / ■ MEDICAL/ ■ WORKERS COMP / ■ LIABILITY

Insurance Company		Policy Holder's Name	Relation to Patient ☐ Self ☐ Spouse ☐ Parent ☐Other
Address		Date of Birth	Male Female
		Insured/Policy Holder Employer	
City/State/Zip		Address	
Insurance Co. Telephone	Date/Time of Accident	City/State/Zip	
ID#	Group#	Deductible	Co-Pay

SECONDARY INSURANCE/MEDICAL

Insurance Co.	Insured Policy Holder	
Address	ID#	Deductible
City/State/Zip	Group#	Co-Pay

NOTIFY IN CASE OF EMERGENCY

Name	Home Phone
Address	Work Phone
City/State/Zip	Cell Phone

REFERRED BY

Doctor	Friend
Address	Advertisement
City/State/Zip	Other

Authorization for Treatment

I consent to examination, treatment and procedures which may be performed during office visits, including emergency treatment considered necessary by the physician and/or his designated providers.

Sign: _____ Date: _____

Rehabilitation and Sports Medicine Associates
Brad Rosen, D.O.

Health History
(Confidential)

3 Executive Court
Germantown, MD 20874
(301) 515-6000

Name _____ Today's Date _____

Age _____ Birth date _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

MUSCLE/JOINT/BONE
- ☐ Fatigue
- ☐ Frequent Falls
- ☐ Loss of Coordination
- ☐ Muscle cramps
- ☐ Muscle spasms
- ☐ Numbness/Tingling where _____
- ☐ Pain where _____
- ☐ Weakness where _____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

GASTROINTESTINAL
- ☐ Lack of bowel control
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting blood

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Cough with eating
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Sinus problems

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Other

WOMEN only
- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Painful intercourse
- ☐ Date of last menstrual period _____
- ☐ Date of last Pap Smear _____
- ☐ Have you had a mammogram? _____
- ☐ Are you pregnant? _____
- ☐ Number of children _____

CONDITIONS Check (√) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Amputations _____
- ☐ Anemia
- ☐ Arthritis type _____
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Bleeding Disorders
- ☐ Blood clot where _____
- ☐ Breast Lump
- ☐ Broken bones where _____
- ☐ Bronchitis
- ☐ Cancer where _____
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chronic Fatigue Syndrome
- ☐ Concussion or Head Injury
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Joint/Bone Surgery where _____ when _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low blood pressure
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Muscle Disease
- ☐ Multiple Sclerosis
- ☐ Myofascial Pain Syndrome
- ☐ Nerve Disease
- ☐ Osteopenia/Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers

FAMILY HISTORY Check (√), if your blood relatives had any of the following.

DISEASE / RELATIONSHIP
- ☐ Arthritis, degenerative _____
- ☐ Asthma, Hay Fever _____
- ☐ Cancer- type _____
- ☐ Diabetes _____
- ☐ Gout _____
- ☐ Heart Disease, Strokes _____

DISEASE / RELATIONSHIP
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Muscle Disease _____
- ☐ Nerve Disease _____
- ☐ Tuberculosis _____
- ☐ Other _____

(All information is strictly confidential)

MEDICATIONS List medications you are currently taking	ALLERGIES To medications or substances
Do you take: ☐ steroids ☐ aspirin/Advil/others ☐ vitamins	
Pharmacy Name Phone	

X-RAYS/IMAGING STUDIES	DATE	LOCATION

HOSPITALIZATIONS/SURGERIES

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐Yes ☐No
If yes, please give approximate dates_____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (√) which substances you use and describe how much you use

	Alcohol	
	Caffeine	
	Illicit Drugs	
	Tobacco	
	Other	

OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Date _____ Reviewed by _____

Rehabilitation and Sports Medicine Associates
Brad Rosen, D.O., L.L.C.
3 Executive Park Court, Germantown, MD 20874
Phone: (301)515-6000 Fax:: (301)515-6039

Billing and Payment Policy

PARTICIPATING WITH INSURANCE

If we participate with your insurance plan, you are responsible to maintain an updated insurance record with this office, and if required, to ensure that your referral is current.

It is your responsibility to understand the terms and conditions of your insurance, which may include, but are not limited to: procedures for filing claims, what medical treatments are covered or require preauthorization; the amount of your co-payment or deductible.

Charges for treatments performed by your physician, which are not within the benefits of your insurance plan, are your responsibility.

Returned checks will be subject to a $25.00 bad check fee, and any outstanding balances older than 30 days will be subject to interest charges of 1.5 % per month. **In the unfortunate event collection procedures are required to collect an outstanding balance, the patient shall be responsible for the reasonable cost of a collection agency, attorney, and/or court costs.**

I hereby authorize my physician to release to my insurance carriers information concerning my illness and treatment and hereby assign to my physician all payments for medical services rendered to me or my dependents.

NOT - PARTICIPATING WITH INSURANCE

If we do not participate with your health plan, the bill for services rendered is your responsibility and payable in full at the time of service. You will be provided with the information for submission to your plan for reimbursement to you.

Returned checks will be subject to a $25.00 bad check fee, and any outstanding balances older than 30 days will be subject to interest charges of 1.5 % per month. **In the unfortunate event collection procedures are required to collect an outstanding balance, the patient shall be responsible for the reasonable cost of a collection agency, attorney, and/or court costs.**

PIP/AUTO INSURANCE

If you have PIP still available, we will bill your auto insurance. If you PIP becomes exhausted during the course of treatment payment in full for all charges not covered by the PIP will be expected at the time of service. Unless other arrangements are made in advance.

By my signature, I indicate that I have read, understand and do hereby accept the terms of this agreement.

Signature: _____ Date: _____
(Parent if patient under 18 years)

Rehabilitation and Sports Medicine Associates
Brad Rosen, D.O.
Patient and Physician Agreement of Office Policy

As our patient you can expect to attain needed medical care that is provided by this practice. You will be treated with consideration and respect by an attentive and professional staff.

You have the right to obtain complete information regarding diagnosis, treatment and prognosis. This information should be communicated in terms that you understand.

You can expect the utmost in confidentiality regarding medical care and records.

Medical records will be transferred or released upon receipt of a signed medical release and payment of the medical records copying charge (records will be released to another physician free of charge).

Patient Responsibilities:

As a patient of Rehabilitation and Sports Medicine Associates I understand it is my responsibility to provide accurate and complete information regarding medical needs, medical history, medications, demographics, and health insurance.

It is my responsibility to report changes in my medical condition medications, demographics or insurance to the physician and/or staff.

It is my responsibility to request additional information about my medical condition or treatment when I do not fully understand the information or instructions given to me.

I understand that there is a medical records copying fee charged for obtaining copies of my medical record, this includes a preparation and retrieval fee and a per page copied fee, and postage as allowed by Maryland Law. This fee must be paid before records will be sent.

I understand that there is a charge for filling out disability and other miscellaneous forms when not presented at the time of my visit. One page is $10.00, more than one page is $20.00.

I understand that my appointment time is reserved for me only and it is my responsibility to give 24 hour notice when I must cancel or postpone an appointment. There are no exceptions unless you are hospitalized.

I agree to pay a $75.00 fee for failure to give 24 hours notice when canceling an appointment. The $75.00 fee also applies to no shows. If this occurs three times or more I will pay $100.00.

I understand that if I arrive late, I will be given only the time left of appointment.

It is my responsibility to call for medication refills before my medicine runs out. Medication refills will only be handled Monday - Thursday from 9 AM to 4 PM

Physician Responsibilities:

Dr. Rosen will see you in a timely fashion. If he is late, you will be given your full appointment allotment.

Your medication refills will be handled in a timely manner according to the above schedule.

Dr. Rosen will answer questions to the best of his ability. If you are unsure of any aspect of care, be sure to ask for clarification.

Your physician will strive to return calls within one (1) business day.

Should your physician decide to terminate services you will be given the names of other qualified physicians.

I appreciate the opportunity to assist in your functional recovery and rehabilitation.

BRosen, DO

Brad Rosen, D.O. Patient / Parent Signature Date