Confidentiality/Privacy Policy

How We Collect Information About You: Plumb Line Physical Therapy, LLC and its employees collect data through a variety of means including but not necessarily limited to faxes, letters, phone calls, emails, voice mails.

What We Do Not Do With Your Information: Information about your medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in intake forms, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about clients who receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with health care services which may require communication between Plumb Line and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies or devices.

If you provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.yourwebpage.org) that simply records the number of visitors and no other data.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Plumb Line. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Plumb Line Physical Therapy

"Helping You Find Center"

PATIENT REGISTRATION

First Name:
Middle Name:
Last Name:
Nickname (Alias):
Gender:
Date of Birth (MM DD YYYY):
Marital Status: (circle) Single Married Divorced Widowed
How did you hear about us?

HOME ADDRESS

Address 1:
Address 2:
City:
State/Province:
Zip Code:

CONTACT

Email Address:
Home Phone:
Mobile Phone:
Preferred Contact Method: (circle) Home Mobile E-mail

SOCIAL SECURITY

Social Security Number:

EMERGENCY CONTACT

Relationship:
Contact Name:
Contact Phone:

FAMILY DOCTOR

Name:

EMPLOYER INFORMATION

Employer Name:

IF PATIENT IS UNDER 18 WHO IS RESPONSIBLE FOR BILLABLE SERVICES?

Name:	
Relationship to patient:	Phone # (if different from above):

The Shoppes at Amity 955 Ben Franklin Highway West, Suite 7 Douglassville, Pa 19518
phone 610.953.3232 PlumbLinePT@aol.com fax 610.953.3230

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Medical History Form

Patients Name:	Date of Birth:
ALLERGIES: Please list any medication(s) you are allergic to:	
Are you latex sensitive? (circle) YES or NO	
List any other allergies we should know about:	
Have you declared the Advanced Directive of Do Not Resuscitate? (circle) YES or NO	
Please X all the following that apply:	

	Alzheimer's		Kidney Disease		Obesity
	Cardiovascular Disease		Chemical Dependency (ie alcoholism)		Osteoarthritis
	Cauda Equina Syndrome		Multiple Sclerosis		Parkinson's
	Cerebral Vascular Accident		Epilepsy		Rheumatoid Arthritis
	Current Infection		Depression		Traumatic Brain Injury
	Diabetes Mellitus		HIV		High Blood Pressure
	Emphysema/COPD/Asthma		History of Cancer		Immunosuppression
	Fibromyalgia		Huntington's		Lupus
	Fracture or Suspected Fracture		Hepatitis		Muscular Dystrophy
	Other	For Women: Are you currently pregnant or think you might be? Yes or No			

Please list any surgeries, injuries or other conditions

Date:	Surgery, Injury, Condition	Date:	Surgery, Injury, Condition

Please X the box for the following OVER-THE-COUNTER medications you have taken in the last week:

	Advil/Motrin/Ibuprofen		Aspirin		Tylenol		Antacid		Laxatives
	Vitamins/Mineral supplements		Decongestants		Antihistamine		Other:		

Please list any prescription medications you are currently taking (INCLUDING pills, injections, and /or skin patches): If you carry a list, we can make a copy.

_____

_____

Have you recently noted any of the following? (Please X the appropriate box)

	Weight loss/Gain		Numbness/Tingling		Fatigue
	Nausea/Vomiting		Fever/Chills/Night Sweats		Weakness

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We are very glad that you are choosing Plumb Line for your physical therapy needs. So that you can be best informed about our policies and services, we ask that you take note of the following:

- Discrimination against consumers is prohibited because of race, color, religious creed, ancestry, national origin, age, sex, or disability.
- We reserve the right to charge a $25 fee for appointments canceled or broken without 24 hours advance notice. This fee will be assumed by you and will not be billed to insurance. To cancel and re-schedule an appointment, call 610-953-3232.
- Please notify our staff of any change in address, phone number or insurance coverage as soon as changes are made.
- If you have a co-pay, your insurance company mandates your co-payment is due at the time of your visit. *Please note that we do not accept credit cards. Payment is accepted in the form of cash or a check.*
- Please know that our communicating with your insurance company regarding your claims is a courtesy to you. You are fully responsible for knowing your insurance coverage and maintaining that knowledge as an advocate for yourself. If your insurance coverage terminates or expires, you are fully responsible for charges incurred.
- Depending on your insurance coverage, you, the consumer, may be monetarily responsible for a portion of your care (i.e. co-pay, co-insurance, or deductible). If your account goes into delinquency, there may be additional costs accrued, including: collection fees, court costs, attorney fees, and administrative fees, up to 30% of your outstanding bill.
- Plumb Line PT is not contracted to work with Medicaid (Access) insurance. If you have this insurance, you may still choose to receive treatment at our facility. However, by signing this form, you are acknowledging that we are not contracted with Medicaid, and you will be responsible for any outstanding payment for services, which is not covered by your insurance.

I _____(signature) have read and understand the terms of being a physical therapy patient at Plumb Line Physical Therapy, LLC. _____ (date)

****

Assignment of Insurance Benefits

- The undersigned authorizes payment of medical benefits to the therapists practicing under this location for any services to me by these therapists. I understand I am financially responsible for any amount not covered by any insurance contract listed above. I agree to pay all those charges for those services and I am aware if I do not pay the balance of my account within a reasonable time, my account will be forwarded to a collection agency. My signature authorizes that insurance payment may be made directly to the clinician and/or facility location providing service to me. _____ (Initials)
- I authorize the release of any medical records of health care, advice, treatment of supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits. _____ (Initials)
- I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

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Confidentiality/Privacy Policy

The medical care we provide our patients is confidential. Plumb Line will protect the confidentiality of your medical information in verbal, written, and electronic form in accordance with Section 164.520 of the Code of Federal Regulations. We will not release information to anyone, without signed written consent, unless they meet the legal exception requirement.

I have received and understand the confidentiality policy. I wish to allow those listed below access to the use or disclosure of my health information: _____

Signature: _____ Date: _____

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Please keep this page for future reference regarding the bulleted statements that you have signed within the new patient packet.

We are very glad that you are choosing Plumb Line for your physical therapy needs. So that you can be best informed about our policies and services, we ask that you take note of the following:

- Discrimination against consumers is prohibited because of race, color, religious creed, ancestry, national origin, age, sex, or disability.
- We reserve the right to charge a $25 fee for appointments canceled or broken without 24 hours advance notice. This fee will be assumed by you and will not be billed to insurance. To cancel and re-schedule an appointment, call 610-953-3232.
- Please notify our staff of any change in address, phone number or insurance coverage as soon as changes are made.
- If you have a co-pay, your insurance company mandates your co-payment is due at the time of your visit. *Please note that we do not accept credit cards. Payment is accepted in the form of cash or a check.*
- Please know that our communicating with your insurance company regarding your claims is a courtesy to you. You are fully responsible for knowing your insurance coverage and maintaining that knowledge as an advocate for yourself. If your insurance coverage terminates or expires, you are fully responsible for charges incurred.
- Depending on your insurance coverage, you, the consumer, may be monetarily responsible for a portion of your care (i.e. co-pay, co-insurance, or deductible). If your account goes into delinquency, there may be additional costs accrued, including: collection fees, court costs, attorney fees, and administrative fees, up to 30% of your outstanding bill.
- Plumb Line PT is not contracted to work with Medicaid (Access) insurance. If you have this insurance, you may still choose to receive treatment at our facility. However, by signing this form, you are acknowledging that we are not contracted with Medicaid, and you will be responsible for any outstanding payment for services, which is not covered by your insurance.

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