Robert Rundorff, MD
Board Certified
Physical Medicine & Rehabilitation

Due to New Laws and HIPAA Guidelines,
This form must be read, signed, and dated.

Authorized Payment Signature on File

I hereby authorize Robert Rundorff, MD to release any information to Health Care Financing Administration, PA Medical Assistance and all subsidiaries and/or my insurance company as required in the course of any examination and/or treatment given by Robert Rundorff, MD. I authorize any holder of Medicare information relating to my treatment to release to any carrier that may be named as my Medigap or Medicare Secondary insurer any and all information needed to determine benefits payable for related services.

I understand that my signature certifies that I have requested and received the services, procedures, and treatments given by Dr. Rundorff. I hereby request that payment be made directly to Robert Rundorff, MD of any authorizing Medicare, PA Medical Assistance and all subsidiaries, and/or any other insurance carrier for any and all services rendered to me through Dr. Rundorff. I agree and understand that all services rendered to me by Robert Rundorff, MD were necessary for treatment of my condition, and that I am personally responsible for all charges which Medicare, PA Medical Assistance and all subsidiaries, and/or any other insurance company may not pay. These include but are not limited to coinsurance, deductible, non-covered services, and self-referrals. I agree to make payment on my account either in full or by the agreed upon payment plan set up by the office of Robert Rundorff, MD and myself.

Medical Records Release

I hereby authorize Robert Rundorff, MD to ***release/obtain*** my medical records regarding my treatment. The purpose for disclosure of the above information is for continued care, insurance, or legal matters. This consent authorizes the release of the aforementioned requested information regarding my treatment, hospitalization, ER or ambulatory health care, and/or evaluation. I understand that I may revoke this authorization at any time in writing, except to the extent that action based on consent has been taken. Further disclosure of the info is prohibited without specific written consent of the person to whom it pertains. This authorization and request is fully understood by me and is made voluntarily on my part.

Notice of Privacy Practice Acknowledgement

I acknowledge receipt/refusal of the Notice of Privacy Practices.

Patient Signature _____ **Date** _____

Guardian Signature _____ **Date** _____

Witness _____ **Date** _____

Robert Rundorff, MD

Physical Medicine & Rehabilitation

PATIENT RECORD OF DISCLOSURES

The HIPPA privacy rule gives individuals the right to request a restriction of uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or PHI be made by alternative means, i.e. fax, mail, email.

I wish to be contacted in the following manner (check all that applies):
This section is to be filled out by the patient.

Home Telephone _____

OK to leave a message w/ information

Leave message w/ call back # only

Work Telephone _____

OK to leave a message w/ information

Leave message w/ call back # only

Written Communication

OK to mail to my home address

OK to mail to my work/office address

OK to fax to this # _____

Other _____

_____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birth date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use/disclosure of/ or requests for (PHI) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses/disclosures made pursuant to a request by the individual. **Please note that uses and disclosures may be permitted without prior consent in an emergency.**

Record of Disclosures of Protected Health Information
To Be Filled Out By The Health Care Facility

Date	Disclosed to Whom	Reason for Disclosure	Disclosed By	Fax or Address

Physical Medicine And Rehabilitation

Patient Medical History Questionnaire

Name: _____ Date: _____ Birth date: _____ Age: _____

Sex: ____ Address: _____ City: _____ State: ____ Zip: _____

SS #: _____ Phone: _____ Cell: _____

Family Doctor: _____ Referring Doctor: _____

Insurance Name and Address: _____

_____

Policy ID#: _____ Group #: _____ Card Holder: _____

Occupation: _____ Employer:_____

Please Briefly Describe Reason For This Visit:

_____

_____

What Tests Have Been Performed For This Problem?

MRI CAT SCAN X-RAY PREVIOUS EMG OTHER

When And Where Were The Tests Performed?

_____

Please List Any Significant Past Medical Diagnosis: (heart disease, epilepsy, diabetes, cancer, emphysema, etc…)

_____

Please List Any Medications You Are Taking:

_____

_____

ALLERGIES TO MEDICATIONS:

_____

_____

Review of Systems: Please List Any Symptoms/Diagnosis That Apply To You:

Cardiovascular:	Metabolic: (diabetes)
Pulmonary:	Gastrointestinal:
Musculoskeletal:	Skin/Eyes/Ears:
Neurological: (seizures)	Other: