Physio Rehab
MVZ WESTPFALZ

Patient Information

Patient Name: Last _____ **First**_____ **MI** _____

Date Of Birth: Day _____ **Month** _____ **Year** _____ **Male or Female** (please circle)

Is client a child? No ___ **Yes**___ (If yes, name, address and phone number of the adult legally responsible for payments due. If no legal paperwork is provided, payment is required at time of service by the adult accompanying the minor child.)

APO Address: _____ **#** _____ **Box #:** _____
City: __APO__ **State:** __AE__ **Zip:** _____

German Address: Street _____ **Number** _____
City _____ **Zip** _____
Cell Phone: _____
Home Phone: _____
Work Phone: _____
E-mail Address: _____
Social Security #: _____-_____-_____

EMERGENCY CONTACT: _____ **Phone:** _____

How did you hear about our office?_____

Sponsor Information

Employer: _____(ie: US Army, US Airforce, NAF, DODS, etc.)
Sponsor Name: _____
Sponsor Social Security #: _____-_____-_____ (for Tricare Patients)
SOFA Expiration Date: Day _____ **Month** _____ **Year** _____

Signature of Patient or Guardian:_____

Date:_____

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Clinic Policies

Thank you for choosing us as your provider. We are committed to providing you with the highest quality of care. Below are our clinic policies, which we require you to read, agree to, and sign prior to any treatment.

Broken Appointments:

Your appointment is reserved exclusively for you. Continuity and consistency of care is important. Therefore, when a scheduled appointment cannot be kept, we request and do require prior notice.

1. **Late Cancellations:** We require a **24 hour advance notice** for rescheduling appointments. If notified short of 24 hours, there will be a **€25 charge.**

2. **No Show:** If you do not show up to your scheduled appointment, you will be charged **a fee of 50€.** This charge will have to be paid in full before a new appointment can be scheduled.

3. **Late Arrivals:** If you are **more than 15 minutes late** for your scheduled time slot, you have **forfeited** your appointment.

Financial:

1. **Patient-Clinic Relationship:** As your health care provider, we would like to emphasize that our relationship is with you, our patient, and not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

2. **Insurance Benefits:** We work with most federal employee insurance programs, and will direct bill your office visits to your insurance. **Insurance is not a guarantee of payment; it may not cover all of your costs.** You may receive a bill if a balance remains after this process. Payment to our clinic is ultimately your responsibility.

3. **Co-Pay Payments:** You may be required to provide co-pay and coinsurance payments in full at the time of service. All of our prices are in Euro, and we accept payments in cash, Visa, MC, and Giro Card. In accordance with German law, we do not accept VAT forms.

I have read, understand, and agree to the above terms and conditions.

Patient Signature _____ **Date** _____

Print Name _____

MVZ International Rehab Westpfalz GmbH Kindsbacher Str. 39d, 66877 Ramstein-Miesenbach
Phone: 06371 95 20 408 • Email: support@mvz-physiorehab.com • Website: www.mvz-physiorehab.com

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Medical History

Name (Last, First, MI): _____ **Date of Birth:** _____

Major Health Concerns: _____

Current Medication List: _____

_____

OTC Medications/Herbal Supplements: _____

_____

Drug Allergies:

_____

Past Medical History

Disease/Condition	Y / N	Disease/Condition	Y/N	Disease/Condition	Y/N
Hypertension		Cancer		Anemia	
Heart Palpitations		Thyroid Disorder		Depression	
Heart Murmur		GI Dirsorder		Anxiety	
Heart Attack		Bleeding Disorder		Headaches	
Stroke		Epilepsy		Eye Disorder	
Diabetes		Kidney Disease		Allergies	
Asthma		Hepatitis		Others:	
COPD		HIV			
Pneumonia		Liver Disease			

Hospitalizations/Surgeries: _____

Family History

	Father	Mother	Paternal Grandparents	Maternal Grandparents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer *Age Diagnosed						
Diabetes						
Epilepsy						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						

Social History

Cigarettes/Tobacco	Past/Current	How Long: Packs/Day:
Alcohol	Past/Current	How Long: Drinks/Week:
Recreational Drugs	Past/Current	How Long: How often:
Exercise	Past/Current	Times/Week: Duration:

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HIPAA Privacy Authorization Form and Data Release

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

I hereby authorize ***MVZ International Rehab Westpfalz GmbH*** to release health information pertaining to the patient named above, to the entities listed below

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Data Release:
In accordance with the European Data Privacy Act (Europäische Datenschutz-Grundverordnung 2016/679), MVZ International Rehab Westpfalz GmbH requests that each patient sign this patient privacy data release and consent form which allows us to share your protected health information (PHI) or electronic health information (ePHI) with other medical service providers (and MVZ-Westpfalz GmbH), as well as your health insurance company.

I hereby authorize email communication for the use and disclosure of my health information, invoices and open balance statements internally within the medical office, to my health insurance company, further treating medical providers and AMC and MVZ Billing Department.

Following Information will be released:

- Results for tests, procedures, x-rays, ultrasounds, MRIs, lab work
- Medical information as follows: prescription pick-ups, medical records, medical reports, diagnoses, appointment days/times
- In addition to the authorization for the release of my protected health information, I authorize the disclosure of information regarding my billing, condition, prognosis, and treatments.

Authorized Persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization shall remain effective indefinitely.

Rights of the Patient:
I understand that I have the right to revoke this authorization in writing at any time. I understand that revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward.

I have read, understand, and agree to the above terms and conditions.

Patient Signature: _____

MVZ WESTPFALZ MVZ PHYSIO REHAB AMERICAN MEDICAL CENTER

Medical Billing Department

1. RELEASE OF INFORMATION: I hereby authorize the MVZ International Rehab Westpfalz Gmbh, MVZ Westpfalz GmbH & American Medical Center Billing Department to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medicalcare, all information needed to substantiate claim and payment.

2. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, accrued interest, and fines. I understand that these additional fees will be my personal responsibility to pay in full.

3. BILLING OFFICE: If you have questions regarding any of your billing statements, our accounts receivable staff at the medical billing office is available to assist you at the number 06371-4049-185 / 186 or via email to billing_amc@mvz-westpfalz.com

4. SELF PAY PATIENTS: I understand that full payment is due at time of service or upon receipt of invoice.

5. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to this clinic sufficient monies and/or benefits for basic and major medical to cover the costs of the care and treatment rendered to myself or my dependent at said clinic. I authorize MVZ International Rehab Westpfalz GmbH, MVZ Westpfalz GmbH & AMC Medical Billing Department to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information. I authorize this clinic and billing staff to release all medical information requested by my health insurance carrier, other physicians or providers, and any other third-party payers.

6. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible for charges not covered by the assignment of insurance benefits.

E-MAIL ADDRESS (Please print): _____

PHYSICAL ADDRESS: _____
❑ (Please check only one) Send correspondence to this address.

APO ADDRESS: _____
❑ (Please check only one) Send correspondence to this address.

CELL PHONE NUMBER: _____

PERMANENT STATESIDE ADDRESS: _____

I have read and understand the practice´s financial policy and I agree to be bound by its terms. I also understand that such terms may be amended by the practice from time to time. I consent to reminders of my open statements to be sent to me via email, European address, or to my permanent stateside address due to relocation

_____ _____

Signature of Patient (or Guardian, if applicable) Date

Billing Department
Konrad-Adenauer-Str. 4
66849 Landstuhl
06371-4049-185 / 186