AMY S. FITZSIMMONS, MD, LLC
PHYSICAL MEDICINE & REHABILITATION
44 SECOND STREET PIKE, SUITE 200
SOUTHAMPTON, PA 18966
PHONE: 215-322-7550 FAX: 215-322-7117

Dear Patient:

All services rendered due to a work related illness or injury will be billed to your employer or your employer's workman's compensation carrier along with a report of the doctor's findings.
We also confirm with your employer that the history of the injury was reported through the proper channels. This is for your information.
Please sign below to acknowledge your understanding of our procedure.

_____ _____
Signature of Patient Date

BELOW MUST BE COMPLETED FOR ALL WORKMAN'S COMPENSATION BILLING:

NAME OF EMPLOYER: _____

BILLS SHOULD BE SENT TO: [NAME AND ADDRESS]

_____

_____

EMPLOYER PHONE NUMBER: _____

WORKMAN'S COMP CLAIM NUMBER: _____

PATIENT SOCIAL SECURITY NUMBER: _____

DATE OF ACCIDENT: _____

DESCRIPTION OF INJURY: _____

HEALTH INSURANCE INFORMATION:

PATIENT PRIMARY HEALTH INSURANCE: _____

SUBSCRIBER NAME: _____ DOB: _____

POLICY/GROUP NUMBER: _____

FINANCIAL RESPONSIBILITY:

I understand that all bills for services rendered will be billed to my workman's compensation carrier or my employer. In the event the service is not covered, I understand that my health (medical) insurance will be billed. I also understand that any balance due after insurance has paid will be my financial responsibility.

_____ _____
Signature of Patient Date

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Dear Patient:

As of April 15, 1990 we are required by law to bill the Insurance Carrier for all auto accidents occurring after that date. However, in order to do this, all of the information below MUST be completed, including an established claim number that can be verified by this office. Please note that we DO NOT BILL ATTORNEYS, only the Insurance Carrier. Also we require that you provider your primary health (medical) insurance information for all auto accident claims.
Please sign below to acknowledge our policy and to authorize release of any information required by the Insurance Carrier to process your claim.

_____ _____
Signature of Patient Date

BELOW MUST BE COMPLETED FOR ALL AUTO INSURANCE BILLING:

NAME OF AUTO INSURANCE COMPANY: _____
ADDRESS OF AUTO INSURANCE COMPANY:

_____

CLAIM NUMBER: _____ DATE OF ACCIDENT: _____

STATE WHERE THE ACCIDENT OCCURRED: _____

NAME OF INSURANCE ADJUSTER: _____

PHONE NUMBER _____

DESCRIPTION OF INJURY: _____

HEALTH INSURANCE INFORMATION:
PATIENT PRIMARY HEALTH INSURANCE: _____

SUBSCRIBER NAME: _____ DOB: _____

POLICY/GROUP NUMBER: _____

FINANCIAL RESPONSIBILITY:
I understand that all bills for services rendered will be billed to my Auto Insurance carrier or my employer. In the event the service is not covered, I understand that my health (medical) insurance will be billed. I also understand that any balance due after insurance has paid will be my financial responsibility.

_____ _____
Signature of Patient Date

July, 2017

Amy S. Fitzsimmons, MD

Family History and Smoking History

PATIENT NAME_____ Date of Birth_____

Family Medical History: (Please Circle)

Heart disease Diabetes Cancer

Stroke

Other neurological (please identify) _____

Other_____

Smoking (please circle the response that best describes your use of tobacco:

Non-smoker

Ex-smoker

Light cigarette smoker (1-9 cigs/day)

Moderate cigarette smoker (10-19 cigs/day)

Heavy cigarette smoker (20 -39 cigs/ day)

Very heavy smoker (40 or more cigs/ day)

cigar smoker

pipe smoker

chews tobacco

snuff user

marijuana

DR. AMY FITZSIMMONS M.D.
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www.amyfitzsimmonsmd.com

Review of Systems

If you are a new patient, do you have any on-going problems listed below?

If you are a returning patient, since your last visit, have you had any of the following problems?

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headaches	Y	N

Eyes		
Blurred Vision	Y	N
Double Vision	Y	N

Neurological		
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Tremors	Y	N

Gastrointestinal		
Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N

Cardiovascular		
Chest Pain	Y	N
Varicose Veins	Y	N

Integumentary		
Skin Rash	Y	N
Persistent Itch	Y	N

Ear/Nose/Throat/Mouth		
Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N

Genitourinary		
Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Respiratory		
Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Hematologic/Lymphatic		
Swollen Glands	Y	N
Blood Clotting Problem	Y	N

Psychological		
Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Patient/Family Signature _____ **Date** _____

Email Address _____

HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

A copy of the Notice of Privacy Practices from Amy S. Fitzsimmons, M.D., LLC is available to review, and by my signature below I acknowledge that I have reviewed it.

Patient name:_____

Name of person reviewing the information (if someone other than the patient):

_____ Relationship to patient_____

Signature_____ Date_____

Patient or Patient Representative

DISCLOSURE OF MY PERSONAL HEALTH INFORMATION

Please write the names of anybody that you may wish to include in the sharing of your medical information. Patients over age 18 should include the names of their parents if they wish for information to be disclosed to them. (*In addition to patient/patient representative please list any person(s) with which we may disclose/discuss patient information.)*

Name of Individual(s)	Relationship to Patient (*parent, sibling, relative, friend, etc.)*
_____	_____
_____	_____

MESSAGES ON ANSWERING MACHINE/CELL PHONE

Can we leave detailed messages on answering machine?

Yes_____ **Phone number** _____ **No**_____

On your cell phone?

Yes_____ **Phone number** _____ **No**_____

FINANCIAL RESPONSIBILITY

I understand that payment of all medical care is due and payable at the time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient's accounts in case of default, including reasonable attorney fees and court costs. I hereby grant permission to Amy S. Fitzsimmons, MD to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Amy S. Fitzsimmons, MD. A photo copy of this authorization shall be considered as effective and as valid as the original.

SIGNATURE_____

DATE_____

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Patient Name_____D.O.B._____Age_____M_____F_____

Address_____City_____State_____Zip_____

Home #_____Work #_____Cell #_____

Email address_____

(Please circle)
Marital Status: Married Single Other Handed: Right Left
Race: Asian Black White Hispanic Primary Language:_____

Chief Complaint:_____

How did the injury occur?_____

Date of Injury_____Place of Injury_____

Primary Care Physician_____Telephone number_____

Who referred you to us?_____Telephone number_____

Name of Employer_____Telephone number_____

Address_____City_____State_____Zip_____

Work related injury: (Circle one) YES NO Auto related injury: (Circle one) YES NO
If yes, when_____

Do you smoke? (Circle one) YES NO Cigarettes_____ Pipe_____ Cigar_____
How long have you smoked?_____ How much do you smoke?_____
Do you drink alcohol? (Circle one) YES NO How much?_____

Height_____ Weight_____

Briefly answer the following questions as best you can (If none, answer "none")

Major Surgeries_____

Chronic Illnesses_____

Medications_____

Drug Allergies_____

Are you taking any herbal supplements (or non-prescription medications)?_____

PATIENT/GUARDIAN SIGNATURE_____DATE_____

Amy Fitzsimmons, MD

Past Medical History

Do you now or have you ever had any problems related to the following (please circle)

Cardiovascular:

CHF(Congestive Heart Failure)	No	Yes
CAD (Coronary Artery Disease)	No	Yes
MI (Heart attack)	No	Yes
MVP (mitral valve prolapse)	No	Yes
CABG (Cardiac by-pass surgery)	No	Yes
HTN (hypertension)	No	Yes
Hypotension (low blood press)	No	Yes
PVD (peripheral vasc. disease)	No	Yes

Gastrointestinal:

History of Peptic Ulcers	No	Yes
Blood in stools	No	Yes
Heartburn/ Acid Reflux	No	Yes
Bowel Incontinence	No	Yes

Psychiatric:

Depression	No	Yes

Hematological/ Lymphatic:

Anemia	No	Yes
Lymphoma/ Leukemia	No	Yes
Deep vein Thrombosis (DVT)	No	Yes
Pulmonary Embolism (PE)	No	Yes

Skin:

Rashes	No	Yes
Psoriasis/ eczema	No	Yes

Respiratory:

Asthma	No	Yes
COPD	No	Yes

Genitourinary:

Female Post-menopausal	No	Yes
BPH (benign prostatic hypertrophy	No	Yes
Prostate Cancer	No	Yes
Bladder incontinence	No	Yes

Neurological:

Paralysis	No	Yes
Stroke	No	Yes
Seizures	No	Yes
Frequent Falls	No	Yes
Multiple Sclerosis	No	Yes

Endocrine:

Osteoporosis	No	Yes
Hypothyroidism (underactive)	No	Yes
Hyperthyroidism (overactive)	No	Yes
Diabetes	No	Yes
Breast Cancer	No	Yes

Allergies:

Latex allergy	No	Yes

Musculoskeletal:

Neck pain	No	Yes
Osteoarthritis (regular arthritis)	No	Yes
Rheumatoid arthritis	No	Yes
Gout	No	Yes
Pseudogout	No	Yes
Back Pain	No	Yes
Joint Pain/ Stiffness	No	Yes