PATIENT INFORMATION

Name:_____ Social Security Number:_____

Address:_____ City, State & Zip Code:_____

Sex: M / F (Circle one) Birth Date:_____ Age:_____

Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____

Primary Contact Number:_____ E-Mail Address:_____

Responsible person's name, address & phone number (for patients under 18):

_____

Name Address Phone #

Referring Physician:_____

(First and last name) City Phone #

Next appointment with referring physician: _____

Primary Care Physician:_____

(First and last name) City Phone #

Date you last saw your referring and/or primary care physician: _____

Employer:_____Occupation:_____

Current medications: _____

_____

Date of illness or injury: _____

Have you had physical therapy, chiropractic care or home health services in the past year? _____YES _____ NO

If yes, please state where:_____When:_____

Have you ever received physical therapy for this diagnosis before? _____ YES _____ NO

If yes, please state when:_____

INSURANCE INFORMATION

Please check all that apply

_____Blue Cross/Blue Shield _____Medicare _____Tricare _____United Healthcare

_____Workers Comp. _____Motor Vehicle Accident Other (please list)_____

Do you have an attorney?_____

Name Phone number

Insurance Company Name_____

ID or Claim Number_____ Group Number_____

ARE YOU THE CARD HOLDER? _____Yes _____No

If not, please provide the following information to help us process your claim:

_____

Card Holder's Name Birth Date Social Security number ID Number of Card Holder

CONSENT AND RELEASE FOR TREATMENT

I hereby authorize the Physical Therapist and PT Assistant to render treatment and procedures in my care. I certify that the answers given herein are true and complete to the best of my knowledge.

_____

Patient (or Guardian) Signature Date

Center for
Physical Rehabilitation
INCORPORATED

Name_____ Account Number_____

OUR FINANCIAL AND CANCELLATION POLICY

1) I understand that the Center for Physical Rehabilitation, Inc. **bills insurance as a courtesy** to our patients. Insurance can be confusing for us and for you. Our staff strives to be educated on the ever-changing insurance requirements such as referral forms, pre-certifications, and use of the "in-network" facilities and providers. In return, we ask that you do the same; together, we can work toward correct reimbursement. **Initial here** _____

2) I understand that **I will be responsible for and must pay** any percentage, any co-pay, any deductible, and any amount not covered by my insurance. In addition, if the insurance company will not pay charges as they are received, I agree to make monthly payments on the account to maintain a current status. **Initial here** _____

3) I authorize payment of benefits as determined by the insurance company to be made directly to the Center for Physical Rehabilitation, Inc. **Initial here** _____

4) For the purpose of collecting any outstanding balance regarding my injury or illness, I authorize the Center for Physical Rehabilitation, Inc., to release any medical or billing information requested. **Initial here** _____

5) In order to provide EVERY patient with the most optimal treatment schedule, we must enforce a cancellation and "no show" policy. We understand that there are certain circumstances that are unavoidable; however, on your 3rd cancellation and/or "no show", a $50 charge will be billed to you. This fee is not billable to insurance. We request that anyone wishing to cancel a scheduled treatment do so before 5 p.m. the day prior to the appointment. Please note that this policy will apply to all patients. Our staff and therapists are not at liberty to exempt anyone from a billed fee. This policy has become necessary to best serve all patients' scheduling needs as well as our productivity and time management demands. Thank you for your understanding and cooperation. **Initial here** _____

6) I understand that if the balance due must be turned over to a collection agency, the agency's collection fee will be added to the total amount due. **Initial here** _____

_____ _____

Patient's or Responsible Party's Signature **Date**