CAROLINA PHYSICAL THERAPY SPECIALISTS

CURRENT & PMHX
CONSENT TO TREAT

PATIENT NAME/ DATE: ____

What caused your pain/ problem? ____

When did it start? ____

Is it getting worse, better or staying the same? ____

On a scale of 0-10 circle your worst level of pain over the last week:

Mild *Moderate* *Severe*

0……..1…..…2……..3……..4……..5……...6……..7……..8……..9……..10

Please indicate on the diagram where you are having pain right now.

What are your goals for Physical Therapy?

____

____

Have you had Physical Therapy for this or any condition in the past? YES NO

Are you currently (or have you received in the last two weeks) Home Health services (PT, Nursing)? YES NO

Please list **ALL** current medications (Prescription & Non-Prescription): Allergies to medications/ LATEX:	Please list **ALL** previous surgeries (include dates):

Please circle all that apply:

Allergies	Epilepsy	Kidney Disease	Diabetes
Anemia	Emotional Problems	Osteoarthritis	Depression
Angina (chest pain)	Emphysema	Osteoporosis	Hypoglycemia
Anxiety	Gallbladder	Pacemaker	Heart Attack
Asthma	Gout	Polio	Whiplash
Bipolar Disorder	Hepatitis	Seizures	Cirrhosis
Bronchitis	Hiatal Hernia	Smoking	HIV/Aide
Cancer	High Blood Pressure	Stroke	Weight Loss

Other:____

CONSENT TO TREATMENT I consent to receive care and/or treatment from **CPTS.**

I hereby certify that all the above information is true to the best of my knowledge. ______________________

Patient's Signature / Date

PATIENT INFORMATION
ASSIGNMENT OF BENEFITS
HIPPA PRACTICE NOTICE

DEMOGRAPHICS

Full Name: ____

Address/City/Zip: ____

Home Phone: ________________ Cell: __________________Work Phone: ____________________

E-Mail: ____ Sex: _____ Birth Date: ____/____/____

SS#: __________________________ Marital Status: Single Married Widowed Separated Divorced

Emergency Contact: ______________________________________ Phone: ________________________

Work Status: Disabled: _____% Retired Student Currently Employed

Employer Name: ____ Ph: __________________

Occupation: ____

Family MD: ____

How did you hear about us? MD Referral Website Friend/ Family Gym Other: ____________________

NOTICE OF INFORMATION PRACTICE

I have read and fully understand **Carolina Physical Therapy Specialists, Inc.**'s (hereafter referred to as **CPTS**) Notice of Information Practices (copy available upon request). I understand that **CPTS** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I hereby consent to the use and disclosure of my personal health information for purposes as noted in **CPTS**' Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: ________________________________ Relationship: _________________________

Name: ________________________________ Relationship: _________________________

I acknowledge and agree to the Assignment of Benefits, Notice of Information Practice (Posted), Financial Agreement (Posted).

____ ____________________________

Patient's Signature (Guardian, if patient is under 18 years of age)/ DATE **Office Staff/ DATE**

FINANCIAL AGREEMENT
PAYMENT POLICY -AOB
BROKEN APPOINTMENT

PATIENT ACKNOWLEDGEMENT OF FINANCIAL AGREEMENT

PAYMENT INFORMATION /ASSIGNMENT OF BENEFITS

*I am paying out-of-pocket for services. (If you select this option, sign and skip the remainder of **this** section*

I have health insurance and would like you to deal directly with my insurance company (Copy of card will be on file)

Policyholder's Information: Name: (if other than patient) ____

DOB: ____/____/_____ Social Security #: ______________________________

Insurance Carrier Name: ____

Insurance Policy/Subscriber #: ______________________________ Group #: ______________________________

Relationship to policyholder: Parent Spouse Other: ____

I hereby instruct and direct the above listed insurance company to pay by check made out and mailed to:
Carolina Physical Therapy Specialists, Inc. 905-B Old Winston Rd. Kernersville, NC 27284

If my/this current policy prohibits direct payment to provider, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. ***This is a direct assignment of my rights and benefits under this policy.*** By signing below I attest to the following: 1) A photocopy of the Assignment shall be considered as effective and valid as the original. 2) I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits. 3) I authorize the use of this signature on all insurance submissions. 4) I authorize CPTS, Inc. to deposit checks made in my name. 5) I understand that I am financially responsible for all charges whether or not paid by insurance (Please refer to the financial agreement that is posted at the front window and/or on the clipboard 'copy available upon request').

INSURANCE: PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED. WE ACCEPT CASH, CHECK, DEBIT, MASTERCARD AND VISA.

Professional services are rendered and charged to you, not your insurance company. Insurance is filed as a courtesy to our patients. Any financial arrangements must be made with the Office Manager prior to starting treatment. All co-payment and patient responsibility amounts not covered by your insurance are due at the time of service. Please inform us of any changes in your address, phone numbers, employment or insurance benefits. You must provide us with an insurance card and we must be able to verify your current coverage and benefits prior to the start of treatment. Due to the many variations of insurance policies, it is important for you to check with your insurance company to make sure that physical therapy services are covered prior to starting your clinical care.

BROKEN APPOINTMENTS: **We require a 24-hour cancellation/no-show notice.** If we do not receive 24-hour notification, you will be charged a $20 broken appointment fee for the spot that was reserved for you.

OFFICE FEES: If you present a check for insufficient funds, or place a stop payment on an issued check, you will be charged a $30 processing fee. Insufficient funds checks will not be reprocessed. You must pay by cash, credit card or money order. All proceeds of insurance are assigned to this office where applicable, but without us assuming responsibility for the collection thereof. During your physical therapy treatment, if your insurance coverage changes or is denied, please notify us immediately.

I agree to abide by all of the above terms:

Patient Name (Print): ____

Patient Signature: ____ **Date:** ______________________