Patient Information

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☐ New Patient ☐ Returning Patient Email: _____

Patient Name: _____

Address: _____
STREET # OR P.O. BOX CITY STATE ZIP CODE

Date of Birth: _____ Age: _____ ☐ MALE ☐ FEMALE SS#: _____

Home Phone: _____ Work or Cell Phone: _____

Patient Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES FOR ANY REASON?	☐ **YES** ☐ **NO**
IS THIS INJURY THE RESULT OF A WORK RELATED ACCIDENT?	☐ **YES** ☐ **NO**
IS THIS INJURY THE RESULT OF AN AUTO RELATED ACCIDENT?	☐ **YES** ☐ **NO**

HOW DID YOU HEAR ABOUT US?

☐ **Newspaper** ☐ **Past Patient / Friend** ☐ **Medical Doctor** ☐ **Website** ☐ **Yellow Pages**

☐ **Other:** _____

DOCTOR / EMERGENCY CONTACT INFORMATION (required)

Referring Physician: _____ Primary Care Physician: _____

Date Last Seen: _____ Date Last Seen: _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

PRIVATE INSURANCE / FINANCIAL RESPONSIBILITY INFORMATION (required)

Person Financially Responsible: _____ Phone: _____

Address: _____

Relationship to Patient: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Is the Patient the Subscriber: ☐ **YES** ☐ **NO** **Is the Patient the Subscriber:** ☐ **YES** ☐ **NO**

RECENT SYMPTOMS

Have you had unusual fatigue lasting 2-4 weeks or longer?	☐ **YES** ☐ **NO**
Have you recently had any unexplained weight change - loss OR gain?	☐ **YES** ☐ **NO**
Have you recently had a fever lasting more than 2 weeks?	☐ **YES** ☐ **NO**
Have you recently had nausea or vomiting?	☐ **YES** ☐ **NO**
Have you noticed any change in your bowel or bladder habits?	☐ **YES** ☐ **NO**
Have you been experiencing pain that occurs or worsens at night?	☐ **YES** ☐ **NO**

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MEDICAL HISTORY | Please check any medical conditions that we should be aware of:			
	Alzheimer's		Blood Disorder / Blood Clot
	Cardiovascular Disease		Concussion / Head Injury
	Cauda Equina Syndrome		Dizziness / Vertigo
	Current Infection		Epilepsy / Seizures
	Diabetes: Type 1 or Type 2		Hepatitis C / Infectious Disease
	Fibromyalgia		Heart Disease/Heart Attack
	Fracture or Suspected Fracture		Joint Replacement
	High Blood Pressure		Lung Disorder (Asthma/Bronchitis/Emphysema)
	History of Cancer		Metal Implants or Pins
	Huntington's		Pacemaker
	Immunosuppression		Scoliosis / Back Disorder
	Lupus		Ulcer / Digestive Disorder
	Muscular Dystrophy		Tuberculosis
	Obesity	**For Women Only**	
	Osteoarthritis		Pelvic Inflammatory Disease
	Parkinson's		Complicated Pregnancies/Deliveries
	Rheumatoid Arthritis		Endometriosis
	Traumatic Brain Injury		Are you pregnant? Yes No
Have you received medical or rehabilitative care for this injury ? Please check all that apply.			
	Chiropractor		Physical Therapy
	Orthopedist		Occupational Therapy
	Neurologist		CT Scan
	Podiatrist		EMG or Nerve Test
	General Practitioner		MRI
	Massage Therapist		X-Ray
	Pain Management		Joint or Spine Injections

Were you hospitalized at any time for **this injury?:** ☐ **YES** ☐ **NO**

If yes please list hospital and date: _____

Please list surgical history by type and date below:

Type: _____ Date: _____ / _____ / _____

Type: _____ Date: _____ / _____ / _____

Type: _____ Date: _____ / _____ / _____

Type: _____ Date: _____ / _____ / _____

(Continued on next page)

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MEDICATIONS LIST | Please fill out completely or provide us with a list of your medications that we can copy:

NAME	DOSAGE & QUANTITY	NAME	DOSAGE & QUANTITY
PRESCRIPTION		**HERBAL**	
		VITAMIN/MINERAL/DIETARY SUPPLEMENTS	
OVER THE COUNTER			
		OTHER	

Allergy History: (medications, food, latex, etc...)_____

ILLNESS OR ONSET OF PAIN INFORMATION (required)

☐ ILLNESS ☐ INJURY What body part is involved: _____ ☐ LEFT ☐ RIGHT ☐ BOTH

Onset of Symptoms: _____

Injury Occurred: ☐ Home ☐ Employment ☐ School ☐ Recreation ☐ Pedestrian ☐ MV A/Auto ☐ Other : _____

** If insurance company is involved as a result of an accident next section must be filled out*

WORKERS COMP / LIABILITY / AUTO CLAIM - PLEASE COMPLETE SECTION BELOW

Date of Injury Was: _____ /_____ /_____

State that incident occured in: _____ Claim Number: _____

Name of Insurance: _____ Adjuster/Contact Name: _____

Phone Number: _____ Extension Number: _____

Has an Attorney Been Obtained: ☐ **YES** ☐ **NO** - if ***YES:*** Attorney Name: _____Phone: _____

EMPLOYMENT INFORMATION (required)

Employer: _____ Phone: _____ ☐ Retired

Address: _____ Job Description: _____

Are you a student? ☐ **YES** ☐ **NO** // ☐ **FULL TIME** ☐ **PART TIME**

To the best of my knowledge, the information that I have given is complete and true.

Patient/Guardian Signature:_____ **Date:** _____ / _____ /_____

Therapist Signature: _____ **Date:** _____ / _____ /_____

General Information

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Thank you for choosing Comprehensive Physical Therapy (CPT) for your physical and/or occupational therapy needs. We are happy to assist you with your recovery. Physical and Occupational services require your consistent attendance in order to meet the goals expected by your referring doctor, your therapist and most importantly, YOU. We will do our best to schedule your therapy appointments at times that are most convenient for you. Please discuss your scheduling limitations with your therapist during your evaluation. CPT will provide you with a printed schedule of your weekly appointments.

Please read the statements below and initial them to indicate your understanding.

_____ I understand that I am required to arrive on time for my schedule appointments.

_____ I understand that if I can not make it to my scheduled therapy appointment **I am required to contact CPT by phone at 570-785-2018 (Forest City), 570-226.7303 (Hawley), 570-342-5333 (Dunmore), 570-282-3302 (Carbondale) to reschedule my appointment for another day within the same week.**

_____ I understand that if I do **not show up for or if I cancel a total of 3 visits over a two week time period that I will be discharged from therapy.**

_____ I understand CPT **may contact me via telephone and leave a detailed message.**

Appointments can be scheduled during our open hours:

Monday	First appointment is 8:00 am	Last appointment is 6:00 pm
Tuesday	First appointment is 8:00 am	Last appointment is 12:00 pm*
Wednesday	First appointment is 8:00 am	Last appointment is 6:00 pm
Thursday	First appointment is 8:00 am	Last appointment is 6:00 pm
Friday	First appointment is 8:00 am	Last appointment is 12:00 pm*

***Occupational Therapy hours may differ**

We do not schedule visits on Mondays, Wednesdays and Thursdays between 1:00 pm and 2:00 pm as this is the daily lunch break.

Patient/Guardian Signature:_____ **Date:** _____

Authorization & Guarantee

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION
I hereby authorize the release of any information, including reports of diagnosis, treatment prognosis, treatment recommendation, benefits payable, as well as any other data pertinent to my treatment to the physician who referred me for therapy, as well as any organization responsible for payment of my account. I also authorize my referring physician to release to Comprehensive Physical Therapy, Inc . any and all medical or other information pertinent to my treatment.

MEDICARE
I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I ok any holder of medical or other information about me, to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance.

GUARANTEE OF PAYMENT
In consideration of services rendered to me by ,Comprehensive Physical Therapy, Inc. I hereby guarantee payment for ,any and all services rendered to which are not covered or allowable by insurance, together with collection costs, including reasonable attorney's fees. I also understand that all bills are due and payable upon presentation and further agree to pay interest or a monthly service charge on all such amounts not paid when due at the rate of 1.5% per month (18% APR).

RETURNED CHECKS
We are happy to accept your personal check, however, there will be a $25.00 fee for any check returned for non-payment to Comprehensive Physical Therapy, Inc.

SUPPLIES
All Supplies are not returnable and are non-refundable.

PRIVATE INSURANCE
I understand that as a courtesy, Comprehensive Physical Therapy, Inc. will bill my/insurers private insurance once only for treatment/visits rendered. Should there be any changes in my insurance coverage during the course of physical therapy, I will provide Comprehensive Physical Therapy, Inc . with the new information . Failure of notification can result in possible denial of claim. In the event that payment is not received in 60 days , for any reason, you will be responsible for the full balance and will then need to deal with your carrier directly.

INSURANCE PRE-AUTHORIZATION
As a courtesy we will make every effort to contact your insurance carrier and attempt to make a determination as to your insurance coverage. However, any such determination of coverage is no guarantee of actual coverage or insurance payment for services rendered. We encourage you to contact your insurance company for any benefit information.

SUPERVISION OF CHILDREN
I understand that this facility is not an appropriate setting for children due to safety reasons for the child(ren), myself and other patients. Any child(ren) allowed in the treatment area may NOT play on the equipment or move around the treatment area without supervision. If the child(ren) becomes a problem due to safety concerns or distracts other patients, you will be asked to leave and reschedule when you have appropriate childcare arranged. Front desk staff and CPT employees are not responsible for supervision of children.

ASSIGNMENT OF BENEFITS
I authorize that the payment of authorized benefits be made directly to Comprehensive Physical Therapy, Inc. for any services that are reimbursable by Medicare, Medicaid, or any other third party sources.

CONSENT FOR TREATMENT
I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or available while a patient at Comprehensive Physical Therapy, Inc.

Signature of Patient / Insured

Patient's Agent / Representative

Witness By

Date

Payment Policy

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CO-PAY /CO-INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the named insurance on the patient registration form and assign directly to Comprehensive Physical Therapy (CPT) all insurance benefits, if any, otherwise payable to me for services rendered.

Co-payments are due at the beginning of each session and not considered billable. This is a contractual agreement between you and your insurance company. This includes Geisinger, Blue Cross/Blue Shield and many other private insurance plans.

If your contract carries a **co-insurance responsibility, a $15.00 payment will be collected at each visit**. This amount may not cover the total amount due for each visit; this amount is taken to offset the final balance and will be credited toward your total responsibility. Once CPT receives notice (EOB) and payment from your insurance carrier for all claims submitted and processed, you will either receive a bill from CPT for any additional unpaid balance, or a reimbursement check for any overpayment.

If your insurance carrier refuses to pay for services rendered, your deductible has not been met, or you classify as a self pay you will be required to pay Comprehensive Physical Therapy all applicable costs for services rendered. In the event of non-payment, your account will be assigned to collections.

OUTSTANDING DEDUCTIBLE

If your insurance policy has an outstanding deductible amount due, CPT will collect at each scheduled visit, either your applicable co-pay/co-insurance amount or $15.00 whichever is greater. This amount may not cover the total amount due for each visit; this amount is taken to offset the final balance and will be credited toward your total responsibility.

CANCELLATION/"NO SHOW" POLICY

A $20.00 fee will be charged to you for each appointment that is scheduled for you that you do not attend or that you cancel without 24 hours notice, this amount will be due at your next visit in addition to your regular co-pay, co-insurance or deductible payment. CPT reserves the right to waive this fee as a courtesy in the event of severe weather, health emergencies and other special circumstances.

This fee is NOT reimbursable by your insurance carrier.

I hereby verify that I have ***read and understand*** the above policy. I authorize Comprehensive Physical Therapy to release all information necessary to secure the payment of benefit and to use this signature on all insurance submissions .

Signature _____ **Date** _____

Print Name _____

Relationship to Patient _____

CPT ACCEPTS CASH, PERSONAL CHECK, VISA, MASTERCARD, AND DISCOVER FOR PAYMENT OF CO-PAYS, CO-INSURANCES AND OUTSTANDING DEDUCTIBLES

Falls Survey

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Name: _____ Date: _____

HAVE YOU FALLEN IN THE PAST YEAR ? ☐ **YES*** ☐ **NO**

*Were you injured as a result of any of these falls? ☐ **YES*** ☐ **NO**

FALLS EFFICACY SCALE

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you can do the following activities without falling?

ACTIVITY:	**SCORE:** **1 = Very confident** **10 = Not confident at all**
Take a bath or shower	1 2 3 4 5 6 7 8 9 10
Reach into cabinets or closets	1 2 3 4 5 6 7 8 9 10
Walk around the house	1 2 3 4 5 6 7 8 9 10
Prepare meals not requiring carrying heavy or hot objects	1 2 3 4 5 6 7 8 9 10
Get in and out of bed	1 2 3 4 5 6 7 8 9 10
Answer the door or telephone	1 2 3 4 5 6 7 8 9 10
Get in and out of a chair	1 2 3 4 5 6 7 8 9 10
Getting dressed and undressed	1 2 3 4 5 6 7 8 9 10
Personal grooming (i.e. washing your face)	1 2 3 4 5 6 7 8 9 10
Getting on and off of the toilet	1 2 3 4 5 6 7 8 9 10
TOTAL SCORE	

Pain Survey

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Name: _____ Date: _____

How would you describe your pain today?

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Pain Possible**

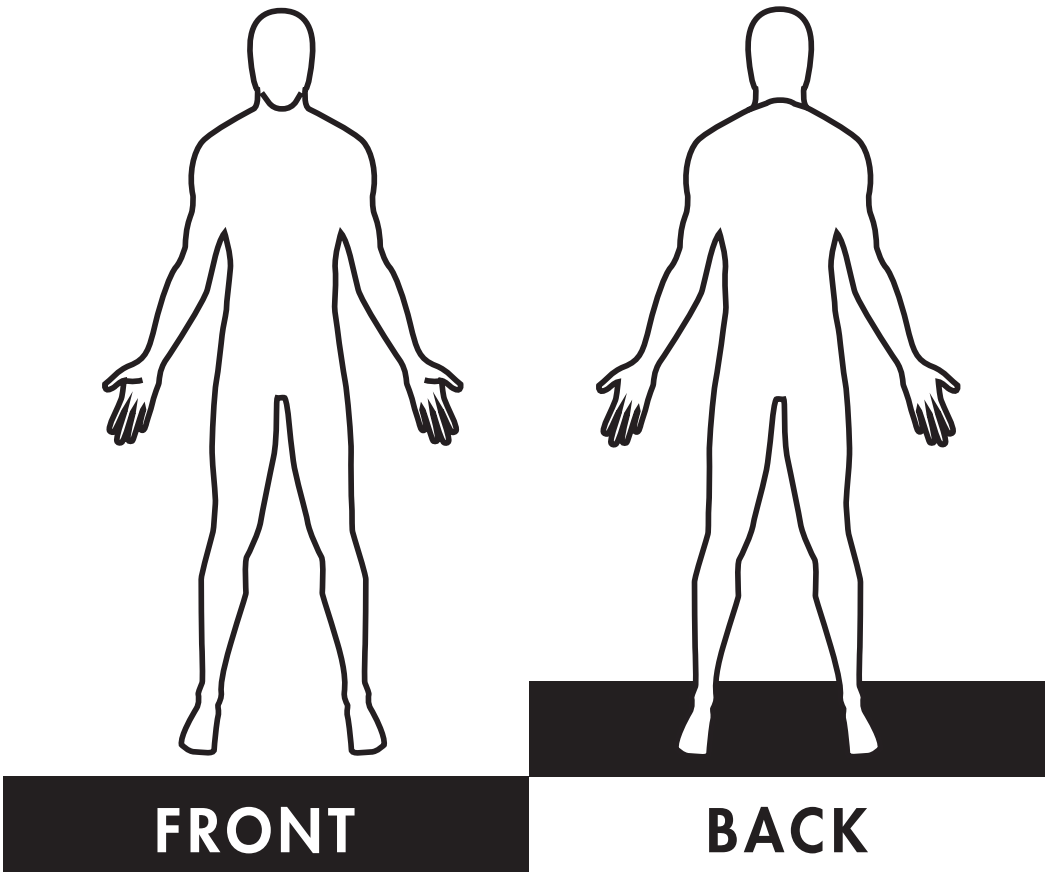
Using the 0 to 10 pain scale, please rate your ***least pain*** in the past 24 hours: _____

Using the 0 to 10 pain scale, please rate your ***worst pain*** in the past 24 hours: _____

Are your symptoms - ***worse*** - ***staying the same*** - ***better*** - since the onset of symptoms?

Using the key provided please mark on the outlines below where you are experiencing any of the following symptoms:

A -Achiness **N** - Numbness **T** - Tingling **S**- Stiffness **H** - Throbbing Pain
P - General Painful Feeling



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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*****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT*****

I am aware that the offices of Comprehensive Physical Therapy are adhering to the Health Insurance Portability and Accountability Act (HIPA) Privacy Practices . I have been given an opportunity to review the written policy .

_____

Please print name (Minor's name if applicable)

_____ _____

Signature (Parent/guardian if applicable) **Date**

What is the best way to contact you? (check all that apply) ☐ **Cell** ☐ **Home Phone** ☐ **E-Mail**

May we leave a voice mail? ☐ **YES** ☐ **NO**

May we leave a message with Family / Household Member? ☐ **YES** ☐ **NO**

If **YES** - Name(s): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because :

_____ **Individual refused to sign**

_____ **Communication barriers prohibited obtaining acknowledgment**

_____ **Other (Please Specify)**

_____

_____

_____

_____