Welcome to Charleston Physical Therapy

Charleston Physical Therapy Specialists
A McKenzie® Certified Clinic

New Patient Registration

Date_____

Name _____
LAST FIRST MI

Address _____
CITY STATE ZIP

Personal Info _____
M/F DOB SSN MARITAL STATUS

_____
HOME # CELL# EMAIL (for follow-up purposes)

Employer _____ Occupation _____ Work# _____

Emergency Contact _____
NAME & RELATIONSHIP PHONE

Name of person we can release information to and their relationship to patient:

(Billing, Appointments, Records) _____
NAME RELATIONSHIP PHONE

Who Referred You to CPT? Friend/Family_____ Physician_____

Area of Injury _____ Injury Date_____

This year: Have you had home health?_____ Or therapy in another clinic?_____

Physician Name _____ Have You Seen Them for this Injury_____

Who is to be Billed: (mark with X) Private Insurance _____ Self ___

Work Comp ___ Claim#_____ Auto/Accident Insurance _____ Claim#_____

Insurance Company Name _____ Member ID _____

Primary Card Holder _____
NAME SSN DOB

Relationship to Patient: (please circle) SELF SPOUSE PARENT OTHER_____

Secondary Insurance Name _____ Member ID _____

Secondary Card Holder _____
NAME SSN DOB

Relationship to Patient: (please circle) SELF SPOUSE PARENT OTHER_____

301 RHL Blvd./Green Road, Southridge, Suite 202, Charleston, WV 25309 Phone: (304) 746-9200 Fax: (304) 746-9202 www.cptwv.com

CONSENT FOR TREATMENT
GUARANTEE OF ACCOUNT AND ASSIGNMENT OF INSURANCE BENEFITS

CONSENT is hereby given Charleston Physical Therapy Specialists (CPT) and the Physical Therapist and Occupational Therapist taking care of me to administer such evaluation and therapeutic procedures that are deemed necessary on an outpatient therapy basis. I am aware that the practice of physical and occupational therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the evaluation and treatment either in the clinic or as a result of my home exercise program. I understand that there is a risk involved with any physical evaluation and/or therapeutic program, such as: increase soreness, fractures, heart attack, pain, and death.

_____
Initials

FURTHERMORE, I accept responsibility for payment of all charges and fees for all outpatient treatment services provided. I further authorize that any insurance benefits that are reimbursable for such service be paid directly to CPT. I consent to the release of any medical information that may be required to verify the justness of any claim made as a result of this outpatient therapy and payment thereof. I understand that CPT will bill my insurance carrier on my behalf for all charges incurred; however, I agree that I am responsible for the full amount of my account (with the exception of certain government insurance plans).

DATE SIGNATURE OF PATIENT OR PATIENTS'S REPRESENTATIVE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to or obtained from the Social Security Administrator or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorize benefits be made on my behalf. I assigned the benefits payable for physician services to the physical therapist or organization furnishing the services or authorize such physical therapist or organization to submit a claim to Medicare for payment to me.

_____
Initials

This is to acknowledge that I received a copy of CPT's notice of privacy practices as required if by HIPPA. _____ Initials

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IMPORTANT INFORMATION REGARDING PAYMENT

Charleston Physical Therapy Specialists

PATIENT PAYMENTS

It is possible you may have to pay a **co-pay** or **co-insurance** for outpatient therapy services.

All patient deductibles, co-pays and co-insurance payments are predetermined by your insurance company and are due at the time of service. Any amount that is deemed to be your responsibility has been assigned by your insurance company. The payment you are making is an estimated payment based on benefit information given by your insurance company.

As much as we try, sometimes we are unable to be exact on the amount that needs to be paid at the time of your appointment, therefore, after your insurance pays there may be a balance left that could be your responsibility.

Overpayment
In very rare cases an overpayment may be made. Again, this is based on information provided to us by your insurance company. If an overpayment occurs, we will issue a refund.

After insurance pays:
If your insurance company has submitted all payments and a balance remains. The remaining balance is your responsibility. A final statement will be sent to you. If your account reflects a credit, a reimbursement will be mailed to you.

We have budget agreements available. Please ask or Call 304-746-9200.

Signature / Guardian Date

Thank you for choosing Charleston Physical Therapy Specialists.
We are sorry there is so much paperwork.

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Health Risk Questionnaire

Name _____ Age ____ Weight _____ Height _____

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Do you have any history of cancer?	YES	NO
Do you have heart trouble?	YES	NO
Do you have high blood pressure?	YES	NO
Do you have diabetes?	YES	NO
Do you use any tobacco products?	YES	NO
Do you have asthma, bronchitis, emphysema?	YES	NO
Do you experience sudden, unexplained shortness of breath?	YES	NO
Do you experience sudden, unexplained rapid heartbeats?	YES	NO
Have you recovered from any acute illness or viral infection?	YES	NO
Has a medical doctor informed you to not participate in exercise?	YES	NO
Have you recently had a checkup from your doctor?	YES	NO

Is there any other health information we should know that may affect your treatment?

_____

Females: Are you pregnant? (Please circle)	YES	NO
Other than my reason for being here today, I am in good health.	YES	NO

Please list the medications you are taking for the reason you are here today.

Please List: _____

_____

_____

_____

_____

Please list any surgery you have had in the last five years.

_____

_____

_____

_____

I understand that if my medical condition or medication changes, I need to inform the CPT staff.

Signature: _____ Date: _____

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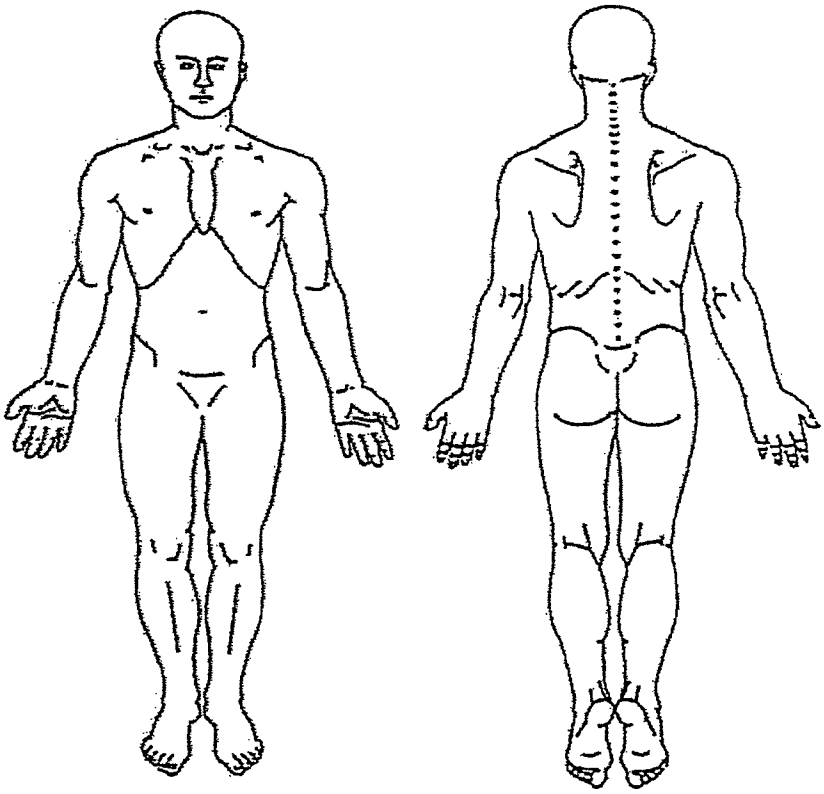
Name _____ DOB ____/____/_____

On the body diagram below, shade in the area(s) where you are having pain, tingling or numbness with this episode.



On the 0 - 10 scale provided below, circle the average pain level for this episode.

0 1 2 3 4 5 6 7 8 9 10
Best Worst

On the 0% - 100% scale provided below, circle the percent of normal function at which you are currently able to preform. This includes; work performance, activities at home, sports and socially with friends.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Worst Best