CABOT PHYSICAL THERAPY

1909 N. Second Street • Cabot, Arkansas 72023 • Office (501) 843-7157 • Fax (501) 843-4617

REFERRING PHYSICIAN ____________________

TODAY'S DATE: ____________________ PRIMARY CARE PHYSICIAN ____________________

Patient's Name ____________________ SS# ____________________

Address ____________________ BIRTHDATE ____________________

City ______________ State ______________ Zip ______________ Martial status: S_____ M_____ W _____ Sep _____ D _____

Telephone: Home ______________ Office ______________ Other ______________

Spouse's Name: ____________________ Spouse's Employer: ____________________

Spouse's Employer's address: ____________________ Phone #: ____________________

If child: Parent's name: ____________________ Parent's employer ____________________

Parent's Employer's address: ____________________ Phone #: ____________________

In case of an Emergency, please Notify: ______________ Phone #: ______________ Relationship: ______________

Patient's E-mail Address: ____________________

PLEASE LIST ANY CURRENT MEDICATION/ALLERGIES/CHRONIC INJURIES/SURGERIES

____

Date of Injury, Accident Date, or Date of Symptoms Started ____________________ (nearest date please)

Is your condition related to: WORK __________ AUTO __________ ACCIDENT __________ SCHOOL __________ OTHER __________

Have you been a patient before? _____Y / N __________ If so, when? ____________________

WHEN IS YOUR NEXT DOCTOR'S APPOINTMENT? ____________________

PATIENT EMPLOYER INFORMATION

Employer name: ____________________ Phone: ____________________

Employer address ____________________ City ______________ State ______________ Zip ______________

Patient's Occupation ____________________

INSURED PERSON (IF NOT PATIENT)

Name ____________________ Phone ____________________

Address ____________________ City ______________ State ______________ Zip ______________

Relationship to patient ______________ S. Sec. # ______________ Date of Birth ______________

INSURANCE

Medicaid # (if applicable) ____________________ Medicare # (if applicable) ____________________

Primary Insurance Company Name ____________________

Secondary Insurance Company Name ____________________

Workman's Compensation: Company Name: ____________________

Address: ____________________

Contact: ____________________ Phone # ____________________

ATTORNEY: Name: ____________________ Phone # ____________________

Address: ____________________

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I request that payment of authorized insurance, prepaid medical plan, Medicare or Medicaid benefits for me, or on my behalf be made to Cabot Physical Therapy. I authorize any holder of medical information about me to release to the insurance company and to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for any charge covered by any insurance. I consent to have therapy services as ordered by my physician and/or as deemed necessary by licensed Physical Therapist of Cabot Physical Therapy.

FINANCIAL POLICY AGREEMENT

I understand that my insurance policy is a contract between me and the insurance company. I request that Cabot Physical Therapy, Inc., file my claims for me, I understand that I am responsible for any amount of my bill that is not covered by my insurance. I agree to pay all court costs and reasonable collection agency and attorney fees, if this claim is placed with a collection agency or attorney for collection. I give permission to call a cell phone with an automatic dialer.

Patient Signature: ____________________ Date: ________ / ________ / ________

Parent or Guardian Signature: ____________________ Date: ________ / ________ / ________

Patient Financial Responsibility

Patient Responsibilities

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

To find out what your insurance plan covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Patients with insurance questions or concerns may also contact Amanda our Office Manager at (501) 843-7157.

While you may have insurance coverage to pay your medical bills, you are ultimately responsible for all charges. You are responsible to notify us of your insurance and to provide the necessary information about your insurance plan; therefore, please have your current insurance card with you at all times, as well as a photo ID such as a driver's license, military ID, or government issued ID.

It is your responsibility to know your insurance company's patient responsibilities and procedures. If proper procedures are not followed, you may be liable for full payment of the bill. If your insurance company requires a referral and/or prior authorization, contact your primary care physician prior to seeing a specialist.

Usual, Customary, and Reasonable Rates

Most insurance companies will pay only what is called a "usual, customary, and reasonable" (UCR) rate for hospital and physician services that are provided by an in-network physician or hospital.

Each insurance company determines its own UCR rates for different medical services.

Usually the UCR rate set by an insurance company is considerably lower than the hospital's or physician's charge for services. Payment by the insurance company is often a percentage of the UCR rate for a given procedure/service.

If your insurance company pays based on UCR, you are then responsible to pay the difference between the UCR payment made by the insurance company and the charge for the service billed by the hospital or physician. This is in addition to the deductible and co-payment/co-insurance that you must pay according to your insurance plan.

Please note that most health insurance plans do not apply the portion of charges above the UCR towards your deductible or annual out-of-pocket maximum.

PATIENT SIGNATURE____________________

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Cabot Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Cabot Physical Therapy. I understand that diagnosis or treatment of me by Cabot Physical Therapy may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice.

Cabot Physical Therapy is not required to agree to the restrictions that I may request. However, if Cabot Physical Therapy agrees to a restriction that I request, the restriction is binding on Cabot Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that Cabot Physical Therapy has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Cabot Physical Therapy's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my therapy services or in the performance of health care operations of the Cabot Physical Therapy. The Notice of Privacy Practices for Cabot Physical Therapy is also provided **[location in the office where NPP is posted]**.This Notice of Privacy Practices also describes my rights and the Cabot Physical Therapy's duties with respect to my protected health information.

Cabot Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Cabot Physical Therapy's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Representative

Date

Description of Personal Representative's Authority

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PATIENT NAME: ______________________________

DOB:______________________ **CHART #**____________

ADDENDUM: PATIENT PRIVACY

I _________________________________ authorize Cabot Physical Therapy to share pertinent "protected health information" with my immediate family members or significant others, as noted below.

Please print the name clearly   Relationship   Date

1.____

Telephone Numbers:______________________________________

2.____

Telephone Numbers:______________________________________

3.____

Telephone Numbers:______________________________________

4.____

Telephone Numbers:______________________________________

I understand, I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other do not divulge or use the information in any way without discussing with me first.

I understand this form is valid until I tell Cabot Physical Therapy of a change.

__________________________________ __________________________

Patient Signature   Date