Patient Demographics

Name: ____ Today's Date: ____________

Last First MI

Address: ______________ City State Zip ______________

Home Phone: ______________ Work Phone :______________ Cell: ______________

□ Male □ Female □ Married □ Child

SSN#: ______________ Date of Birth: ____________ Email: ______________________

Emergency Contact:____

Name Relationship Phone Number

EMPLOYEE INFORMATION

Employer: ______________________________ Occupation: ______________________

Employer Address: ______________________ City: ____________ State:________ Zip:__________

Employer Contact: ______________________ Number: ______________________

Who recommended us to you?: ______________________ May we thank them for this referral?: □ Y □ N

Referring Physician:____________________ Date of RX: ____/____/_____ Frequency/Duration:__________

NEXT DR.'S APPOINTMENT: ____________ Prior Physical Therapy for this injury? □ Y □ N

Is injury related to: **WORK AUTO ACCIDENT FALL SPORTS N/A** If yes: Date:_____/_____/______

Diagnosis/Chief Complaint:____

Accident Details:____

Insurance Information (Please fill out completely and provide insurance card)

Primary Ins.:	Phone #	Group #
ID #	Name of Insured:	Relationship to Patient:
Insured DOB:	Insured SSS#	Employer:
Secondary Ins.:	Phone #	Group #
ID #	Name of Insured:	Relationship to Patient:
Insured DOB:	Insured SSS#	Employer:

Worker's Comp Information/Personal Injury Protection

Employer:	Phone #
WC Insurance CO	
Adjustor:	Phone #:
Claim #	Fax #:

Medicare Patients Only

Are you currently receiving Home Health Care Services for any reason? □ Y □ N

If yes, provide the name of the agency: ____________________

Start Date of Service: ____________________ Discharge Date: ____________________

TO THE BEST OF MY KNOWLEDGE THE INFORMATION PROVIDED HEREIN IS CORRECT.

Signature: ____ Date: ____________________

Conditions of Treatment and/or Admission

CONSENT FOR TREATMENT/ADMISSION

I hereby authorize the Physical Therapist(s) in charge of the care of ____________________________________ and Complete Performance Physical Therapy, PLLC to administer and perform such diagnostic studies and/or procedures that are considered medically necessary or deemed necessary for diagnosis and treatment.

PAYMENT GUARANTEE

I hereby guarantee payment of my insurance portion due to Complete Performance Physical Therapy, PLLC at the time that services are rendered unless other arrangements have been made in advance. *The patient's total account is due in full at discharge, with allowance made for insurance coverage approved, and assigned to Complete Performance Physical Therapy, PLLC prior to dismissal. Patient co pays are due at the time of services rendered.*

MEDICAL RECORDS

If you need your medical records, please ask for our Medical Records Request Form, and understand we have a $25.00 Medical Records Fee. If a third party requires medical records from Complete Performance, we will need a fully signed Medical Release form from that agency faxed over to the Medical Records Department at info@completeperformancept.com ; a charge greater than $25.00 may occur for third party requests. Please note that Complete Performance Physical Therapy has a 72 business hour policy to return the requested documents to the appropriate party.

Signature: ________________________ Relationship:_____________________ Date: ______________

HIPAA

Health Information Portability & Accountability Act

I am aware that a copy of the HIPAA (Health Information Portability & Accountability Act) is available for my review in the lobby of Complete Performance Physical Therapy as pertains to my treatment.

1) I authorize my doctor and his clinic staff to release my private medical information to all medical sources involved in my care, including insurance health plans, physicians health plans, physicians, health care professionals, hospitals, clinics, laboratories, pharmacies, medical facilities, or other healthcare providers that have provided payment, treatment or services to me or on my behalf.

2) If we identify that you have missed an appointment time or you are not scheduled for future appointments per your treatment plan, we will call the phone number(s) you have provided. Please list any phone numbers YOU DO NOT WANT US TO LEAVE A MESSAGE ON.

   Phone number(s) to exclude: _________________________________

3) On occasion we have phone calls from patients' friends and family members regarding their appointment times. Please list the names of any people you **DO NOT WANT** our facility to give this information to.

NAME	RELATIONSHIP

I understand these authorizations and/or exclusions will remain in effect until such time I request in writing, that these be withdrawn. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____________________________________ Date: __________________________

Printed Name:____

Confirmation Number:______________________________

Authorization Number (If Applicable):__________________

Insurance Verification

Full Name: ______________________________________ Member ID:____________________

Date: __________________ DOB: ______________

Group Number:____

Verification of coverage is not a guarantee of benefit. Actual plan coverage and benefit payments are determined when a claim is received by your insurance company. Therefore, the information below is an estimate of your coverage.

Verification/Authorization Given By: _________________________________

Billing Address: ____ Phone Number: ___________________

Effective Date: _______________ When does insurance calendar year begin/end:

Annual Deductible: $___________ How much of the deductible has been met: $ _________________

OOP: $_______________ How much of the OOP has been met: $ _______________

Ins./Pt. Portion: ______% ____________ % Co-Pay per visit $_____________

Max/Cal Yr. $_______________ # Visits/Cal Yr.: ______________

Is preauthorization required: Y N Is a PCP Referral Required Y N

If Yes, who is PCP? ____________________________

Medicare Cap Met: __________________ Managed Care Replacement Plan: Y N

Medicare is: Primary Secondary Tertiary Home Health Episodes:_________________

If authorization is required, fill out this section:

Auth Number: ________________________ # Visits ______________ Dates:_______________

Procedure Codes:

97163(6)	PT Evaluation		97110	Therapeutic Exercise	
97014	E Stim Unattended		97112	Neuromuscular Re-ed	
97530	Therapeutic Activity		97140	Manual Therapy	

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____________________________ and assign directly Complete Performance Physical Therapy, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Complete Performance Physical Therapy, PLLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

___________________________________ ____________________________ _____________________

Responsible Party Signature Relationship Date

WORKER'S COMPENSATION ONLY:

I authorize Complete Performance Physical Therapy, PLLC to contact my employer to obtain authorization that this is a worker's compensation claim. Should my employer not approve this as a worker's compensation benefit, I will supply my personal medical insurance information to Complete Performance Physical Therapy, PLLC and authorize Complete Performance Physical Therapy to file my claims with my insurance company. I further understand if for some reason my insurance carrier does not pay for services rendered, I will be responsible for paying Complete Performance Physical Therapy. In addition, I authorize and direct my insurance benefits to be paid directly to Complete Performance Physical Therapy, PLLC.

Signature: ____

Date: ________________________