

New Episode/Case Form

Have you been a patient at our facility since April 2012? If no, please fill out Demographic Intake Form. If yes, please confirm demographic info in our secure data base with our office staff.

(PLEASE PRINT)

Patient information:

First name: _____ MI: ___ Last Name: _____ DOB: _____

Medical Information for this episode of care:

Referring physician: _____ Primary Care physician: _____

What part of your body will we be treating? _____

When did your symptoms start, or date of your injury? _____

If you've had surgery for this, what was the date of your most recent surgery? _____

If you are a Medicare patient, are you currently receiving any health-related services at your home (home health nurse or aide)? Yes / No If yes, with what agency: _____

Injury Related To: Employment Automobile accident/State of accident _____ Other

Worker's Compensation: (If work related injury please list info below)

Employer: _____

Employer address: _____

Supervisor: _____ phone #: _____

Work Comp. Insurance: _____

Case Manager/Adjuster: _____

Claim #: _____

If unable to work, list last full work date: _____

Insurance information: (Please allow us to make copies of your insurance cards)

Primary Insurance: _____ Secondary Insurance: _____

Patient's relationship to insured: Self *Spouse *Child

*If not, "self" please list Insured's Name _____ DOB: _____

Insured's SS#: _____ - _____ - _____ Phone: _____

Insured's Address: _____

Get Better Faster.....Stay Better Longer!
Carlsbad Physical Therapy & Wellness Center, LLC

New Episode/Case Form

Consent for Treatment: I hereby give written consent to be evaluated by a licensed physical or occupational therapist and treated by same therapist and/or his/her supervised physical or occupational therapist assistant or technician employed by this facility. _____ initials

Assignment of Insurance Benefits: I authorize my insurance company to make payment directly to this facility for services rendered to me. _____ initials

Filing of Insurance claims: (Primary and Secondary Insurance Only) are filed directly with the insurance carrier(s) as a courtesy to our patients. Our office does not normally verify your secondary insurance. Occasionally, we may call if we are unfamiliar with a particular insurance. We are happy to assist you by verifying your Primary insurance benefits and checking for prior authorization or approval requirements to the best of our abilities. Our office will not be responsible for incorrect information passed on to us by the insurance company. Ultimately you are responsible for knowing/understanding your benefits and any prior authorization requirements and paying the balance of your account.

Therapy charges: Our goal is to get you better as quickly and cost-considerate as we can. The medical codes/charges for therapy services can be confusing as our services are not billed as "visits" like a doctor's office. Our charges are based upon specific services performed by the clinician and most are billed in 8-15 minute units. It is difficult to know ahead of time exactly what services the clinician will perform as they make adjustments with each visit based upon your improvement and tolerance. If you have a "percentage" co-insurance, we will estimate your percentage due based upon an average charge of \$150.00 per hour long visit. Any balance will be billed or refunded upon receipt of your final insurance payment/charge. Our staff is eager to help you with any questions you have about the services we provide or the sometimes overwhelming medical insurance/billing process.

Financial Policy: Our primary mission is to deliver the best and most comprehensive physical and occupational therapy care available. We want to get you back to your normal activities as quickly, and with the least amount of visits possible. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

- 1) Pay any out of pocket obligation on each day of service. We accept cash, checks, credit cards, and debit cards (with credit insignia's).
- 2) Our Deferred Payment Plan allows you to pay over time (with no interest). See our office staff for the contract information.
- 3) Apply for Financial aid/assistance. If paying your out of pocket obligation will result in financial hardship, you may apply for assistance/waiving of all or part of your financial obligation. See our office staff for the application and document requirements.

Based upon the insurance information we've been given, we estimate your out of pocket obligation to be \$ _____/per visit. Other: _____

We will not assume financial responsibility for any services rendered. My signature acknowledges that, ultimately, I am responsible for ensuring the insurance's requirements for referrals or prior approval are in place. I acknowledge that I am ultimately responsible for ensuring my insurance pays as it should and am obligated for paying any remaining balance within 60 days of invoice (unless I have opted to participate in the deferred payment plan).

Signature of Patient/Guardian/Responsible Party

Date

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Demographic Intake Form

(PLEASE PRINT)

Patient information:

Title (Mr., Mrs., Ms.): _____

First name: _____ MI: _____ Last Name: _____

Nickname (Alias): _____ Gender: Male Female

DOB: _____ SS#: _____ - _____ - _____

**Home phone: _____

**Cell phone: _____

Work phone: _____ Ext: _____

**We use an automatic messaging system to send a reminder TEXT or PHONE call the day before your appointments. Please circle the number above that you would like us to use for this reminder system. If you circle Home, you'll get a voice reminder. If you circle Cell, you'll get a text message reminder.

Email: _____

Address: _____

City/State/Zip _____ / _____ / _____

Employer: _____

Emergency Information:

Contact/First name: _____ Last name: _____

Relationship to you: _____ Phone #: _____

Photo Consent:

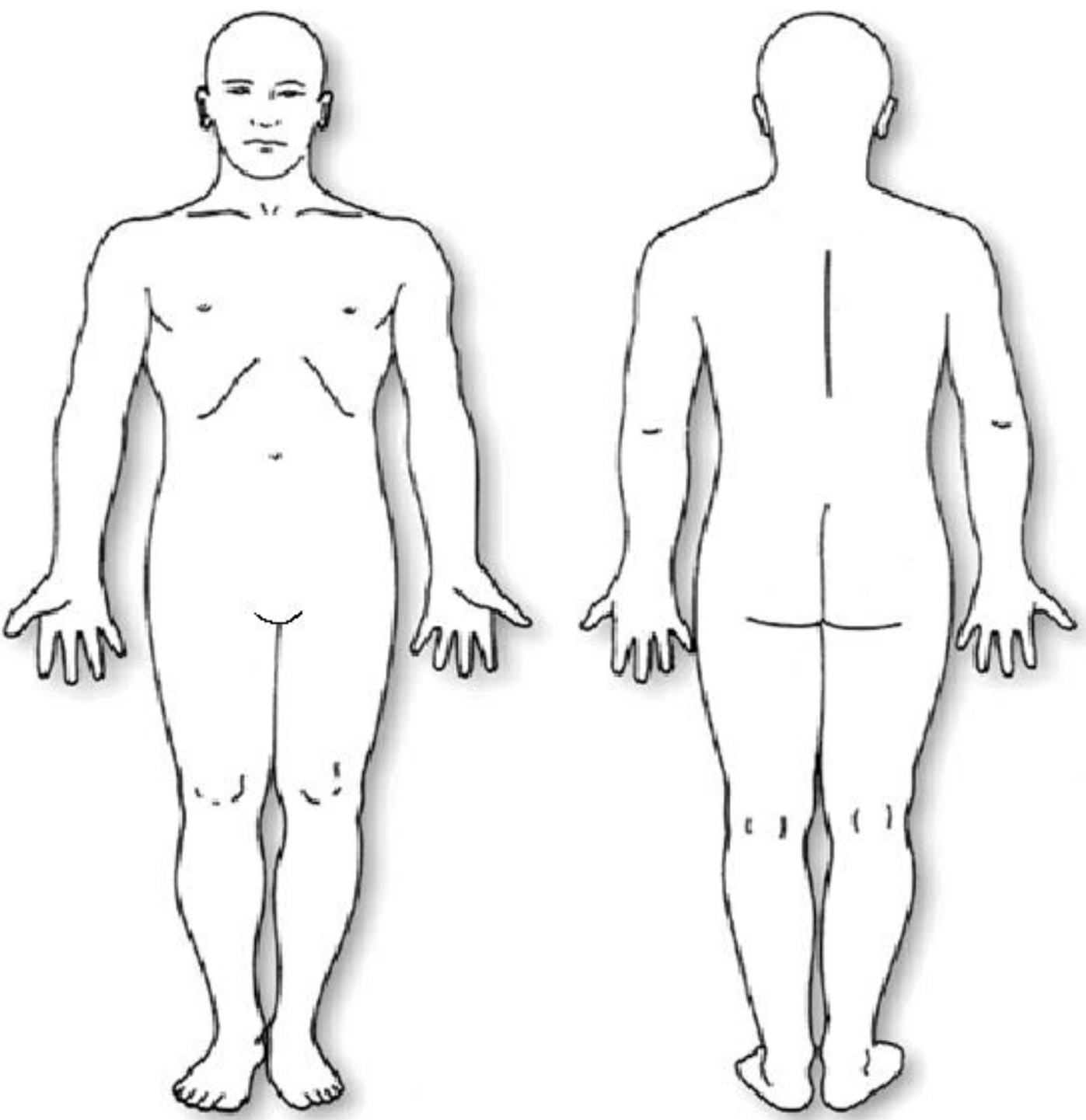
There might be times that we ask to take a photo/video of you to document your progress or for marketing purposes. Your signature permits us to use photographs/videotapes for treatment and/or marketing purposes. It also releases us from any responsibility which may result from the taking of such images or any publicity which may result from the use of such images.

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Patient Pain Diagram

Date: _____

Patient Name: _____



Color in the areas where you feel pain