The Cantrell Center for Physical Therapy & Sports Medicine, P.C.

Patient Information **Date:** ____________________

Name: ____________________________ Age:_______ Date of Birth:____/____/____
(First, MI, Last)

Address: ____
Street & Number City State Zip

Mailing Address if different: ____
Home Phone#:(____)____________ Cell Phone #:(____)____________ Work Phone#: (____)__________ x:____
May we (circle one): Text / Email you an appointment reminder?
Cell phone carrier (circle one): AT&T, Verizon, Sprint, T-Mobile, Other:______________

Sex:____ SSN#:________________ Email Address: ____________________
Occupation: ______________ Your Employer: ____________________
Address: ____
City State Zip

Marital Status
M S D W
❑ ❑ ❑ ❑

Employment Status
❑ Employed Full-time ❑ Employed part-time ❑ Unemployed
❑ Student Full-time ❑ Student Part-time ❑ Retired

Spouse/Guardian Information

Spouse/ Parent/Guardian Name: ____________________________ SSN#:______________
First MI Last
Relationship: ____________________ Mobile Phone #:(____)____________
Date of Birth:___/___/___ Employer Name:________________ Work Phone #:(____)____________

Spouse/ Parent/Guardian Name: ____________________________ SSN#:______________
First MI Last
Relationship: ____________________ Mobile Phone #:(____)____________
Date of Birth:___/___/___ Employer Name:________________ Work Phone #:(____)____________

Emergency Contact:______________________ **Phone Number:** (___)______________
Relationship: ____________________

Patient Medical History: (PLEASE CHECK ALL THAT APPLY)

❑ SMOKE ❑ DRINK ❑ DRUGS ❑ EXPOSED TO HIV ❑ PREGNANT – IF SO, HOW LONG?______________

Arthritis - Osteo		High Blood Pressure	
Arthritis - Rheumatoid		Diabetes	
Dentures		Fractures	
Epilepsy		Heart Pacemaker	
Allergies		Migraines	
Do you carry Epipen?		Liver Disease	
Swelling		Shortness of Breath	
HIV/Aids		Tumor	
Cancer		Excessive Bleeding	
Metal Implant		Pelvic Pain	
Heart Problems		Asthma	
Incontinence		Other:	
Osteoporosis			

LIST SURGERIES AND YEAR:

YEAR	SURGERY
______	____________________
______	____________________
______	____________________
______	____________________

Injury Date or Date pain began: ____________________

❑ **No Accident**

If Injury - Where did Injury Occur?
❑Home ❑Work ❑Auto Accident- What State?________
❑Other______________

Describe Symptoms/Pain/Injury you are being treated for today.______________________________

Patient:______________________________ Acct.#:____________

How Did You Hear About Our Office?

___ From a Former Patient: Who? _____________________________

___ Are you a returning patient. When were you Last seen here. ___________

___ Yellow Pages/Internet & Which directory/ Search engine? _____________________

___ Your Employer: Who? ______________________________

___ Insurance Benefit Plan: Plan Name: __________________

____Friend/Family: Who? ______________________________

____Other: ____

Friends of The Cantrell Center are very special to us. Did anyone "other than" your physician recommend **you to The Cantrell Center? We would like to thank them.**

Name: ____

Address: ____

Do you have a Physician order for therapy? Yes ______ No______

Referring Physician: ______________________________Date of Next Doctor's Appointment: ___________

Telephone# ______________________

If you were referred to us by a doctor other than your primary care physician: Who is your family physician so that we may forward your progress reports to him/her?____

Telephone #______________________

Have you been treated by another: (**Please CIRCLE all that apply**) physical therapist, chiropractor, or Home Healthcare agency since January 1st of this year? No ______ Yes______

If yes, . Have you been discharged from their facility? No_________ Yes _________

Date last seen/treated _______________

Please fill out the following information for each that applies:

Physical Therapy Office _________________________________ Phone #: _______________________

Chiropractor's Office ____________________________________ Phone #:______________________

Home Health Care Agency_________________________________ Phone #:______________________

Date you were **discharged** from Home Health Care?____________________

Have you had X-rays/MRI? When?__________________________ Where?__________________________

____

Cash Pay benefits were explained to me prior to my first visit.

Initial Evaluation: $200.00 (due prior to Visit)

PT Therapy Visit: $160 per 1 hour of treatment

(Each additional 15 min of treatment will be an additional $40 charge.

I understand and agree my payment is required each visit. _______ (please initial)

I have received and understand The Cantrell Center's Notice of Information Practices. I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Cantrell Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. _____________(please initial)

ASSIGNMENT OF BENEFITS STATEMENT & CONSENT FOR TREATMENT

______________________________   ______________
Patient   Account #

CONSENT FOR TREATMENT

I ______________________________, voluntarily give my consent to the Cantrell Center for Physical Therapy and Sports Medicine, P.C. to evaluate and treat my condition including the consent to receive telehealth services.

Authorization For Release Of Medical Information And Assignment Of Benefits

For consideration of services rendered by The Cantrell Center for Physical Therapy & Sports Medicine, P.C., I hereby guarantee payment of all charges incurred by above named patient. I authorize this office to release/receive any information acquired in the course of my examination and treatment to other physicians, hospital, clinics or The Cantrell Center for Physical Therapy & Sports Medicine, P.C. I authorize The Cantrell Center for Sports Medicine, P.C. to request credit information from any credit bureau.

I authorize The Cantrell Center to release information regarding my care/treatment to the following family members (spouse, children, and siblings): ____

____

It is the patient's responsibility to keep personal items with them at all times.

I also authorize The Cantrell Center to photograph me for the purpose of identity in my medical records not to be shared with any outside sources. I understand and authorize that if photos are taken of my injury during the course of treatment, that these photos can be shared with insurance carriers or attorneys if requested to insure payment and/or for educational purposes.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR 100% OF ALL CHARGES. I ALSO UNDERSTAND THAT IN THE EVENT OF DEFAULT OF PAYMENT OF MY ACCOUNT, A 30% COLLECTION FEE WILL BE ADDED TO MY OUTSTANDING BALANCE. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL ATTORNEY AND LEGAL FEES INCURRED TO COLLECT THIS BILL.

____
PATIENT NAME (PLEASE PRINT)

______________________________   ______________
PATIENT SIGNATURE   DATE SIGNED

____
RESPONSIBLE PARTY (if other than patient)

THE CANTRELL CENTER
FINANCIAL POLICY

Thank you for choosing us as your physical therapy provider. We are committed to providing the best care possible for all ages and all needs in a comfortable and friendly environment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions regarding fees, FINANCIAL POLICY, or your responsibility.

WE ACCEPT CASH, CHECK*, OR VISA/MASTERCARD/DISCOVER**

I will be paying by: ☐ **CASH** ☐ **CHECK*** ☐ **VISA/MASTERCARD/DISCOVER****

**All returned checks will result in a $25.00 service charge. | **A 3.5% charge is applied to all credit/debit card transactions.*

***PLEASE NOTE:* CO-PAYMENT is due at time of service (including deductibles and non-covered services).**

REGARDING INSURANCE

If you have insurance, our staff will call and verify benefits and eligibility prior to your first visit, please note that benefits given are a "**quote**" and **NOT a guarantee of payment or coverage**. Coverage and payment is determined once your insurance receives and processes your claim. As a courtesy, we will file your primary and secondary insurance. We will help you to receive maximum benefits. If you have not met your annual deductible, you will be required to pay a $160.00 deposit. You will be required to pay all co-payments, estimated coinsurance, and deductibles at the time of service or on a weekly basis. Your estimated insurance payment is based on benefits given by your insurance company. We are contracted with many insurance companies and accept the negotiated allowable fees as agreed by contract. If we are not contracted with your insurance, we are not responsible for amounts of any insurance company's arbitrary determination of usual and customary rates.

Once insurance has completed payment on your account, the balance is due in full. **With prior credit approval**, we will accept a minimum monthly payment of 20% of the total balance ***or*** $60.00, whichever is greater. Any difference from the estimated amount and the amount actually paid by your insurance company is YOUR responsibility. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

NON-INSURANCE PATIENTS

All patients without insurance will be required to pay in full at the time of service. Credit cards, cash, and checks will be accepted.

LIABILITY ACTION-LITIGATIONS

It is your responsibility to make our office staff aware if court action on your case is a possibility. With prior approval, we will accept a letter of protection or attorney lien on third party claims. You and your attorney must sign a lien. Payment of the bill is the responsibility of the individual who receives treatment, not the individual who is being sued. A monthly payment plan will be established for you at the beginning of treatment. If claim has not settled within 90 days from discharge date, then payment must be made in full. We accept Cash, check or Visa/MasterCard.

MISSED APPOINTMENTS

It is your responsibility to notify us 24 hours prior to cancellations or rescheduling. A missed appointment or cancellation without such notice will be subject to a nonrefundable charge of $50.00 per missed appointment, which will be billed directly to the patient. This charge is not billable to commercial insurances or Worker's Compensation. Please help us serve you better by keeping scheduled appointments.

My signature below acknowledges my understanding and willingness to comply with these policies.

______________________	______________________	___/___/20___
Signature	Witness	Date

01/31/24