

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): Verizon, Sprint, AT&T, 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? _____

LIST SURGERIES AND YEAR:
YEAR SURGERY

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			

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 No, do you intend to be a Cash Pay patient? Yes ___ No ___**

Do you intend to file with Insurance? Yes ___ No ___


Name of Insurance Carrier: Primary: _____ Secondary: _____

Tertiary: _____

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? _____

My insurance benefits have been verified and explained to me prior to my first visit. Note: this is an "**estimate**" and **not a guarantee of benefits** as described by your insurance carrier(s): \$ _____ / _____ Deductible(s), Co-insurance _____ / _____ % and/or _____ / _____ co-pay/ **I understand and agree my co-pay is required each visit and/or co-insurance payment is required a minimum of once per week.** _____ (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 hereby authorize the payment of benefits of my insurance policy to be paid directly to The Cantrell Center for Physical Therapy & Sports Medicine, P.C., for services rendered. I further authorize this office to release/receive any information acquired in the course of my examination and treatment to my insurance company, 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, 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.

As a service to you, our office will bill your primary and 2nd insurance companies for charges incurred. All deductibles, co pays, and coinsurance balances will be due on the date services are rendered.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY. 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.

Signature

Witness

____/____/20____
Date

01/31/24