CARSON PHYSICAL THERAPY

Referring Doctor____________________ **Primary Care Physician** ____________________

Name ____________________ **DOB** ____/____/____ **SS#** _____-_____-____

Address____________________ **City** __________ **State** _____ **Zip** ______

Home Phone (_____**)**______-______ **Work/Cell Phone (**_____**)**______-______ **Email** ________________

Gender______ **Marital Status**______ **Your Sport or Activity (if applicable)** ________________

Employer____________________ **Job Title** ________________

Emergency Contact Person ____________________**Emergency phone number (**_____**)** ______-______

Date of Injury/Onset________________ **Next Physician Appointment date:**________________

What are you being seen for today?________________ **Is this accident related?**______ **Auto/Other**

Is this work related?__________**How did you hear about our clinic?**________________

if client is under 18 years of age....

Parent's Name ________________ **Parent's Employer**________________

Parent's SS# ______-______-______ **Parent's Work / Cell Phone (**_____**)**______-______**Email** ________________

Medical History

In an effort to serve you better and manage your condition, we need a little information on your medical history. Please answer the following. Don't worry about elaborating, the therapist will ask follow-up questions as needed according to your answers.

Please note any other healthcare professional you are seeing and why.

- ☐ **Medical Doctor** **Reason** ________________
- ☐ **Chiropractor** ________________
- ☐ **Dentist** ________________
- ☐ **Psychiatrist/Psychologist** ________________

Please note whether you have experienced the following:

❑ Yes ❑ No	Heart Disease
❑ Yes ❑ No	Hypertension
❑ Yes ❑ No	Stroke
❑ Yes ❑ No	Diabetes
❑ Yes ❑ No	Cancer
❑ Yes ❑ No	Psychological Illness
❑ Yes ❑ No	Arthritis
❑ Yes ❑ No	Osteoporosis
❑ Yes ❑ No	Ulcers, Stomach Problems
❑ Yes ❑ No	Skin problems
❑ Yes ❑ No	Lung Problems
❑ Yes ❑ No	Other:

List any surgeries you've had: ________________

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Please note if you are currently affected by any of the following (please circle):

Are you allergic to cortisone? ❑ Yes ❑ No
Are you allergic to latex? ❑ Yes ❑ No
Do you have a pacemaker? ❑ Yes ❑ No

CONSENT, DISCLOSURE, AND PRIVACY

I hereby give consent to the physical therapists at Carson Physical Therapy, Inc. to provide physical therapy treatments to myself for conditions warranted by physical therapy treatment.

If I am to have my account paid by health insurance, workman's compensation or auto insurance, I hereby request and authorize my insurance company(s) or Medicare to pay directly to Carson Physical Therapy any proceeds payable under the terms of my policy(s) for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospital and physical therapy pre-certifications, deductibles, co-insurance, and co-payment.

It is the policy of Carson Physical Therapy to help the client in obtaining full benefits from his/her insurance company. However, the clinic is not obligated to withhold our statements or to wait until settlement has been made before receiving payment for our services.

I understand that data collected during my visits to therapy may be used for research purposes.

I have been provided an opportunity to review and received a copy of Carson Physical Therapy's privacy policies.

Our office is happy to file medical claims with your insurance carrier. Once we have received payment from your insurance company, any remaining balance on your account not already collected is due and payable within thirty (30) days of receiving the insurance payment. Co-pays are due at time of service. The benefits that we explain to you are only an estimate of benefits. It is your responsibility to know your insurance policy and how they pay **(i.e. your deductible, your copay, and/or co-insurance)**.

Carson Physical Therapy also reserved the right to utilize the services of a collection agency in collecting delinquent accounts. If a collection services is utilized, I agree to pay all such costs incurred in collecting my account balance, including attorney's fees. If my check is returned for insufficient funds, I agree to pay a returned check fee of $25 for each occurrence.

____ **Date:** ________ / ________ / ________

Signature of Client (Parent or Guardian if client is a under 18 years of age)

INDIVIDUAL PATIENT'S AUTHORIZATION FOR PROTECTED HEALTH INFORMATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

Protected Health Information to Be Used and/or Disclosed
The only protected health information that Carson Physical Therapy might disclose is physical therapy documentation. This would include daily notes, evaluations and progress reports, home exercise programs, self assessments, and referral information.

If this is agreeable to you, please initial here:______

Should you feel there is any other information you wish to be disclosed or not disclosed please explain: ____
____

People or Organizations Permitted to Receive and Use
Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.
( ) Referring Physician
( ) Insurance
( ) Attorney
( ) Worker's Compensation
( ) Other – Explain:____
( ) Coach
( ) Athletic Trainer
( ) Immediate family (father, mother, children, sibling)

Purposes of the Requested Uses and/or Disclosures
The only reason Carson Physical Therapy will disclose protected health information is to your medical care and for reimbursement reasons. Carson Physical Therapy provides your physician with a copy of your evaluation and also progress notes. Upon request by your insurance company, we will provide them with copies of all physical therapy documentation.

If this is agreeable to you, please initial here:______

Should you feel there is any other purpose this information should or should not be disclosed please explain: ___________________________________
____

ENDING THE AUTHORIZATION
Select one of the following two choices.
( ) This authorization will end on the following date: ______ / ______/ 20____
( ) This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure.
Describe the event below:
( ) 10 years after last visit
( ) Other – Explain:_____________________________________

CHANGING YOUR MIND ABOUT THIS AUTHORIZATION
I understand that I may revoke this authorization at any time by giving written notice to the Contact Office listed below. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

SIGNING THIS AUTHORIZATION
SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT
I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

INDIVIDUAL PATIENT'S SIGNATURE
I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____________________________________Date:____ / _____/ 20____

If this authorization form is signed by a personal representative for the individual patient, complete the following:

Personal Representative's Name: ____

Signature ____________________________________ Date: ___/____/20______

Relationship to Individual Patient:____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.