PAYMENT POLICY AND BILLING PROCEDURES

Unless 100% coverage has been verified with no copay, no co-insurance, and no deductible, you are responsible for the copay/co-insurance per visit and/or deductible not covered by your insurance company. This payment is required at the time of each visit. Your verified copay amount is $_____ per visit. If you have a plan with co-insurance, the verified covered % by your Insurance per visit is _____% and your % due is _____% per visit. Your deductible amount is $_____. This payment is due in full at the time of your first visit. We accept cash or check for your payments. There is a $25.00 charge for all returned checks. You will receive a monthly statement that will show you the status of your account.

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your claim with your insurance company: however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to Physical Therapy, Occupational Therapy or Counseling Services. Many insurance companies have stipulations that limit the benefit in some way, such as number of visits, supplies, and deductibles.

SUPPLIES/MEDICAL RECORDS POLICY

Payment for all supplies not covered by insurance is due at the time of service. Medicare patients: Medicare does not cover supplies. You are responsible for payment for all supplies used in your treatment at time of each visit. Items not covered by your insurance are your responsibility. We have an agreement with you, not your insurance company for receipt of payment. Please be aware of this and plan to make payment arrangements accordingly. Worker's Compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will become your responsibility.
Medical records are provided within 30 days after the date of your request. Medical records are billed out at .60 per page. Payment is required before records will be released.

CONSENT TO TREATMENT

I understand I have been referred by my physician or myself for treatment and care, to Comprehensive Therapy Centers. Comprehensive Therapy Centers has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered before receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Comprehensive Therapy Centers provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of Comprehensive Therapy Centers. I hereby authorize Comprehensive Therapy Centers to furnish my insurance company(s), attorney, or legal representative all information, which said parties might request concerning my present illness or injury. I hereby assign Comprehensive Therapy Centers all money to which I am entitled for medical expenses related to the service reported herein, but not exceed my indebtedness to Comprehensive Therapy Centers. It is understood that any money received from; the above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I am financially responsible to Comprehensive Therapy Centers for charges not covered by my insurance company. I understand that in unlikely instances where Comprehensive Therapy Centers has made all efforts to collect on an account, Comprehensive Therapy Centers reserves the right to transfer the account to a collection agency. In this event, I understand that I remain responsible for these charges in addition to any percentage based collection fees, costs per our prevailing collection company contract, attorney fees, court costs, service fees and associated miscellaneous fees and costs associated with collection on this account. Comprehensive Therapy Centers or any assignee may contact me or responsible parties at any telephone number provided, or subsequently discovered, regarding the services or billing. I certify by my signature that I have read and agree to this information.

_____

Patient Name (Print)

_____

Patient Signature Date

_____

Parent or Guardian Name (Print)

_____

Parent or Guardian Signature Date

Patient Attendance Policy

It is our policy at Comprehensive Therapy Centers to give prompt, courteous service to all our patients. In order for us to deliver service in this manner, we schedule individual appointments. We try to schedule these appointments so that they are convenient to you. It is important for you to arrange your schedule so that you can be on time for these appointments.

If you are unable to attend or you will be late for your appointment, please notify the center in advance. If necessary, at that time you can reschedule the missed appointment. Failure to attend your session may hinder your recovery process. By notifying the center in advance if you cannot keep your appointment, or if you will be late, we are able to rearrange our schedule to accommodate you as well as other patients. We urge you to call 24 hours prior to your scheduled appointment if you need to cancel your appointment to avoid a **$50 fee**. Please be aware that your Insurance will not pay for your late cancel or no show fees.

There is a $50 fee for late cancellations and for no shows.

Phone Contact

Occasionally we may need to contact you by phone to confirm or reschedule an appointment.

☐ **Yes** ☐ **No**	May we call you at home?
☐ **Yes** ☐ **No**	May we leave a message if you are not home?
☐ **Yes** ☐ **No**	May we call you at work

Thank you for you assistance.

I have read and understand the above. I understand that attendance at each therapy session is important to my recovery and will notify my therapist if unable to attend a session so that it may be rescheduled.

Patient Signature_____ Date_____

Or,

Parent/Guardian _____ Date_____

For each no-show or cancelled visit, doctors, employers, and workman 's *compensation will be notified. Two no-shows and/or three cancelled visits will result in discharge from physical therapy. We hope you take your therapy and recovery as seriously as we do.*

Por cada visita cancelada se *notificara a su doctor, empleadores, y su sueguro* de *compensacion* de *trabajadores. Dos faltas y/o tres visitas canceladas resultara en el cierre* de *su tratamiento. Esperamos que tome su terapia su recuperacion tan serio como nosotros lo toma*os.

ACKNOWLEDGEMENT AND DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

I acknowledge that I have received a copy of Comprehensive Therapy Centers **Notice of Privacy Practices**. By signing below I consent to Comprehensive Therapy Centers use and disclosure of protected health information about me for treatment, payment and healthcare operations. I also confirm that I DO NOT desire restriction on Comprehensive Therapy Centers use or disclosure of protected health information for treatment, payment and healthcare operations.

_____ _____

Signature of Patient (or Patient's Representative) Date

There may be times when it is necessary for an individual directly involved in your care to call our facility to inqui personal health information or billing information.

I authorize Comprehensive Therapy Centers to disclose my health information that is directly related to my current treatment at Comprehensive Therapy Centers to these individual(s), for purposes of their role in my treatment or payment for the health services that I have received.

There may be such persons involved in your care such as spouse, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues. By listing these individuals below and signing below, you authorize Comprehensive Therapy Centers to release personal health information to them.

NAME	RELATIONSHIP

_____ _____

Signature of Patient (or Patient's Representative) Date

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

☐Power of Attorney ☐Guardian ☐Surrogate Decision-Maker
☐Executor of Legal Rep. ☐Parent ☐Other (please specify) _____

Provide documentation or explanation of your authority to act for the patient: _____

_____

☐ I DO desire restrictions on Comprehensive Therapy Centers use or disclosure of protected health information For treatment, payment and healthcare operations. In doing so, I elect to pay for all services up front. I request the restrictions listed on the following page.

_____ _____

Signature of Patient (or Patient's Representative) Date

INDIVIDUAL/FAMILY INTAKE FORM

Patient Name: _____ Date: _____

Date of Birth: _____ Marital Status: _____

If Minor Child:

Parent/Guardian Name: _____

Do you presently have custody of child? ☐ Yes ☐ No

Visitation schedule: _____

In home are:

Adult: _____ Age: _____

_____

_____

Children: _____ Age: _____

_____

_____

EMERGENCY CONTACT PERSON:

Name: _____ Relationship: _____ Phone: _____

Past/Present health problems of client: _____

_____

_____

_____

_____

Current Medications: _____

_____

Prescribing Physician: _____

_____

Past Counseling experiences: _____

_____

_____

General goals for counseling: _____

_____

_____

_____

THE BURNS ANXIETY INVENTORY®

Instructions: The following is a list of symptoms that people sometimes have. Put a check (✓) in the space to the right that best describes how much that symptom or problem has bothered you during the past week.

Symptom List:

	NOT AT ALL	SOMEWHAT	MODERATELY	A LOT
CATEGORY I: ANXIOUS FEELING				
1. Anxiety, nervousness, worry, or fear.				
2. Feeling that things around you are strange, unreal or foggy.				
3. Feeling detached from all or parts of your body.				
4. Sudden unexpected panic spells.				
5. Apprehension or a sense of impending doom.				
6. Feeling tense, stressed, "uptight", or on edge.				
CATEGORY II: ANXIOUS THOUGHTS				
7. Difficulty concentrating.				
8. Racing thoughts or having your mind jump from one thing to the next.				
9. Frightening fantasies or daydreams.				
10. Feeling that you're on the verge of losing control.				
11. Fears of cracking up or going crazy.				
12. Fears of fainting or passing out.				
13. Fears of physical illness or heart attacks or dying.				
14. Concerns about looking foolish or inadequate in front of others.				
15. Fears of being alone, isolated, or abandoned.				
16. Fears of criticism or disapproval.				
17. Fears that something terrible is about to happen.				
CATEGORY III: PHYSICAL SYMPTOMS				
18. Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19. Pain, pressure, or tightness in the chest.				
20. Tingling or numbness in the toes or fingers.				
21. Butterflies or discomfort in the stomach.				
22. Constipation or diarrhea.				
23. Restlessness or jumpiness				
24. Tight, tense muscles.				
25. Sweating not brought on by heat.				
26. A lump in the throat.				
27. Trembling or shaking.				
28. Rubbery or "jelly" legs.				
29. Feeling dizzy, lightheaded, or off balance.				
30. Choking or smothering sensations or difficulty breathing.				
31. Headaches or pains in the neck or back.				
32. Hot flashes or cold chills.				
33. Feeling tired, weak, or easily exhausted.				

----------THE BURNS DEPRESSION CHECKLIST®----------

	NOT AT ALL	SOMEWHAT	MODERATELY	A LOT
1. Sadness: Have you been feeling sad or down in the dumps?				
2. Discouragement: Does the future look hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a failure?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself for everything?				
6. Indecisiveness: Do you have trouble making up your mind about things?				
7. Irritability and frustration: Have you been feeling resentful and angry a good deal of the time?				
8. Loss of interest on life: Have you lost interest in you career, your hobbies, your family, or your friends?				
9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you think you're looking old or unattractive?				
11. Appetite changes: Have you lost you appetite? Or do you overeat or binge compulsively?				
12. Sleep changes: Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?				
13. Loss of libido: Have you lost interest in sex?				
14. Hypochondriasis: Do you worry a great deal about your health?				
15. Suicidal impulses: Do you have thoughts that life is not worth living or think that you might be better off dead?				

Name: _____

Date: _____