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 would like 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 tomam*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 inquire about your 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:
Adults: _____ 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: _____

_____

_____

1. In the past three years has your child:

a. Stolen more than once? No_____ Yes_____ Ages_____
b. Run away from home more than once? No_____ Yes_____ Ages_____
c. Lied often? No_____ Yes_____ Ages_____
d. Set fires? No_____ Yes_____ Ages_____
e. Been truant from school? No_____ Yes_____ Ages_____
f. Deliberately destroyed other's property? No_____ Yes_____ Ages_____
g. Broken into someone's house, building or car? No_____ Yes_____ Ages_____
h. Been physically cruel to animals? No_____ Yes_____ Ages_____
i. Used a weapon in a fight? No_____ Yes_____ Ages_____
j. Had more than one physical fight with peers? No_____ Yes_____ Ages_____
k. Had Juvenile Court involvement? No_____ Yes_____ Ages_____

If yes, when and what were the charges? _____

Names of probation officer / court worker: _____

2. Over the past three years has your child?

a. Repeatedly lost his/her temper? No_____ Yes_____ Ages_____
b. Often argued with adults? No_____ Yes_____ Ages_____
c. Often defied or refused adult requests or rules? No_____ Yes_____ Ages_____
d. Deliberately annoyed other people? No_____ Yes_____ Ages_____
e. Blamed others for his/her mistakes? No_____ Yes_____ Ages_____
f. Been easley annoyed by others? No_____ Yes_____ Ages_____
g. Been angry and resentful? No_____ Yes_____ Ages_____
h. Been spiteful or vindictive? No_____ Yes_____ Ages_____
i. Sworn a lot or used obscene language? No_____ Yes_____ Ages_____

3. Over the past year has your child had:

a. Excessive or unrealistic worry about future events? No_____ Yes_____ Ages_____
b. Excessive concern over past behaviors? No_____ Yes_____ Ages_____
c. Excessive concern about his/her competence? (athletic, academic, social) No_____ Yes_____ Ages_____
d. Complaints of headaches or stomachaches? No_____ Yes_____ Ages_____
e. A lot of self-consciousness? No_____ Yes_____ Ages_____
f. Tension and difficulty relaxing? No_____ Yes_____ Ages_____
g. Excessive need for reassurance from others? No_____ Yes_____ Ages_____

4. Over the past year has your child:

a. Had excessive fear of weight gain? No_____ Yes_____ Ages_____
b. Had excessive weight loss? No_____ Yes_____ Ages_____
c. Felt fat when he/she isn't? No_____ Yes_____ Ages_____
d. Dieted excessively? No_____ Yes_____ Ages_____
e. Used laxatives, diuretics or speed? No_____ Yes_____ Ages_____
f. Self-vomited after meals? No_____ Yes_____ Ages_____

5. Recently has your son or daughter used:

a. Alcohol? No_____ Yes_____ Occasionally_____ Frequently_____
b. Amphetamines? No_____ Yes_____ Occasionally_____ Frequently_____
c. Marijuana? No_____ Yes_____ Occasionally_____ Frequently_____
d. Cocaine? No_____ Yes_____ Occasionally_____ Frequently_____
e. Sedatives, hypnotics, anxiolytics? No_____ Yes_____ Occasionally_____ Frequently_____
f. Hallucinogens? No_____ Yes_____ Occasionally_____ Frequently_____
g. Inhalants? No_____ Yes_____ Occasionally_____ Frequently_____
h. Opioids? No_____ Yes_____ Occasionally_____ Frequently_____

6. **Over the past year has your son or daughter:**

a. Had a significant depressed (sad) mood?	No_____	Yes_____	Minor_____	Major_____
b. Been very irritable?	No_____	Yes_____	Minor_____	Major_____
c. Been less interested in most activities?	No_____	Yes_____	Minor_____	Major_____
d. Gotten less pleasure than usual from activities he/she enjoys?	No_____	Yes_____	Minor_____	Major_____
e. Lost a good deal of weight?	No_____	Yes_____	Minor_____	Major_____
f. Complained of or has a lack of appetite?	No_____	Yes_____	Minor_____	Major_____
g. Been unusually tired and listless?	No_____	Yes_____	Minor_____	Major_____
h. Had difficulty falling asleep at night?	No_____	Yes_____	Minor_____	Major_____
i. Had difficulty remaining asleep at night and waking earlier than normal?	No_____	Yes_____	Minor_____	Major_____
j. Felt guilty or worthless (low self-worth)?	No_____	Yes_____	Minor_____	Major_____
k. Had difficulty concentrating in school or at home?	No_____	Yes_____	Minor_____	Major_____
l. Mentioned suicide or felt like dying?	No_____	Yes_____	Minor_____	Major_____
m. Attempted suicide?	No_____	Yes_____	Minor_____	Major_____
n. Been more withdrawn then usual?	No_____	Yes_____	Minor_____	Major_____

7. **Over the past year has your son or daughter acted:**

a. Fidgety, squirmy?	No_____	Yes_____
b. Restless?	No_____	Yes_____
c. Impulsive?	No_____	Yes_____
d. Poorly attentive?	No_____	Yes_____
e. Easily distracted?	No_____	Yes_____
f. Unable to remain seated?	No_____	Yes_____
g. Talked excessively?	No_____	Yes_____
h. Very difficult to discipline?	No_____	Yes_____

8. **Were there serious marital/couple/family problems during this period?** No_____ Yes_____

9. **How were the problems manifested in the home? (yelling, physical violence) and how did the child react to these problems?**_____

_____

10. **To your knowledge, has your child been sexually victimized (fondled, sexually abused, raped)?** No____ Yes___
If yes, at what age (s)? _____ and by whom? _____

11. **Was your child ever physically or emotionally abused?** No_____ Yes_____
If yes, at what age (s)? _____ and by whom? _____

12. **Has your child recently (while not on drugs):**

a. Heard voices talking to him/her (hallucinations)?	No_____	Yes_____
b. Had bizarre or very unusual thoughts?	No_____	Yes_____
c. Exhibited odd behaviors?	No_____	Yes_____

13. **Please describe, as best you can, your child's personality (emotional makeup). Be as descriptive as you can:**

_____

_____

14. **Please describe what forms of discipline you have tried and how successful or unsuccessful your methods have been. Do both parents/partners discipline the same way? Are you consistent in your handing out of consequences? What do you use as a consequence?**

_____

_____

_____

_____