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.

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

Worker's Compensation Patient Attendance Policy

If you are covered by worker's compensation insurance and you fail to keep the appointments that are recommended by your therapist and physician, the appropriate parties need to be notified of your absence and will also be noted in your chart. This may include your physician, employer, insurance company, and case manager/rehabilitation nurse. Please understand that failure to actively participate in your rehabilitation program may have a negative effect on your worker's compensation coverage.

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 tomamos.

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

PAST MEDICAL HISTORY FORM

Patient Name:____ Date:______

Are you presently working? ▯Yes ▯No

Date of next physician's visit: ______/______/______

Date of injury / onset: ______/______/______

Have you ever had these symptoms before? ▯Yes ▯No

Check which apply to your symptoms:

- ▯ Work related injury
- ▯ Recurrence of previous injury
- ▯ Motorvehicle accident
- ▯ Injury related to lifting
- ▯ Injury related to falling
- ▯ Cause unknown
- ▯ Athletic / recreational injury
- ▯ Other__________________

Have you had a related surgery? ▯Yes ▯No

Do you have, or have had any of the following?

	Yes	No
Diabetes	▯	▯
Chest Pain / Angina	▯	▯
High Blood Pressure	▯	▯
Heart Disease	▯	▯
Heart Attack	▯	▯
Heart Palpitations	▯	▯
Pacemaker	▯	▯
Headaches	▯	▯
Kidney Problems	▯	▯
Are you Pregnant	▯	▯
Cancer	▯	▯
Osteoporosis	▯	▯
Bowel / Bladder Abnormalities	▯	▯
Urine Leakage	▯	▯
Asthma / Breathing Difficulties	▯	▯
Liver / Gallbladder Problems	▯	▯
Smoking	▯	▯
Stroke / CVA	▯	▯

	Yes	No
Allergies to Aspirin	▯	▯
Allergies to Heat	▯	▯
Allergies / Poor tolerance to Cold	▯	▯
Other Allergies	▯	▯
Hernia	▯	▯
Seizures	▯	▯
Metal Implants	▯	▯
Dizziness / Fainting	▯	▯
Recent Fractures	▯	▯
Surgeries	▯	▯
Skin Abnormalities	▯	▯
Sexual Dysfunction	▯	▯
Nausea / Vomiting	▯	▯
Ringing in you ears	▯	▯
Rheumatoid Arthritis	▯	▯
Special Diet Guidelines	▯	▯
Hypoglycemia	▯	▯
Other:______________________________		

If yes on any of the above, please briefly explain and give approximated date:

____

____

____

____

____

Is there any other information regarding you past medical history that we should know about?

____

____

____

____

____

Are you presently taking medication? ▯Yes ▯No

If yes, please list what medications and for what condition:

____

____

____

____

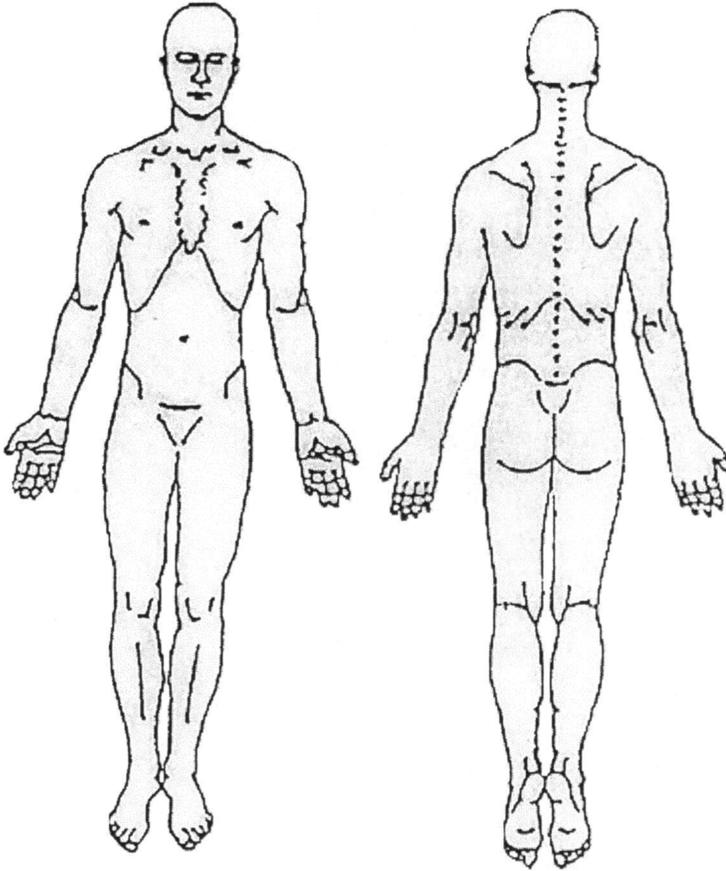
In the rare instance of an emergency, whom should we contact?

Name: ______________________________________

Phone Number:__________________________________

Do you participate in any sports, exercise programs, or activities on a regular basis? ☐Yes ☐ No

Please indicate below where your symptoms are located.



KEY:

Numbness	=====
Pins & Needles	000000000
Burning Pain	xxxxxxxxx
Stabbing Pain	/////////

If you are having pain, please rate the intensity of you pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: ____________________.

______________________________ ______________

Patient's Signature Date

______________________________ ______________

Signature of Guardian if patient is a minor Date

______________________________ ____/____/____

Therapist Signature Date