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/co-insurance is ________ per visit. Your deductible is $________per plan year. There is a $25.00 charge for all returned check.

Payment for all supplies are due at time of visit. Worker's Compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will be your responsibility.

CONSENT TO TREATMENT

I understand I have been referred by my physician or myself for treatment and care, to Comprehensive Therapy Centers. 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 my physician and/or recommended by my therapist. By signing this agreement, I consent to have Comprehensive Therapy Centers provide treatment and care a 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; above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I am financially 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.

ATTENDANCE POLICY

If you unable to attend or you will be late for your appointment, please notify the center in advance. We urge you to call 24 hours prior to your scheduled appointment if you need to cancel your appointment.

If you are covered by workers 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.

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 or cell?
☐ **YES** ☐ **NO** May we leave a message if you are unavailable?
☐ **YES** ☐ **NO** May we call you at work?

I authorize CTC to disclose my health information that is directly related to my health treatment to these individual(s). By listing these individuals below and signing below, you authorize CTC to release personal health information to them: If you do not wish to add anyone to your disclosure put "none" and sign and date.

Name	Relationship

I acknowledge that I have received a copy of Comprehensive Therapy Centers Notice of Privacy Practices. By signing below I consent to CTC use and disclosure or protected health information about me for treatment, payment and healthcare operations. 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 Name:____Date:____ _ _ ______

In the rare instance of an emergency, whom should we contact? Name: _____________________Phone: ( ) ______

Date of injury / onset: _____/_____/_______ Have you ever had these symptoms before? Yes No

Have you had a related surgery? Yes No Have you fallen one or more times in the last year? Yes No

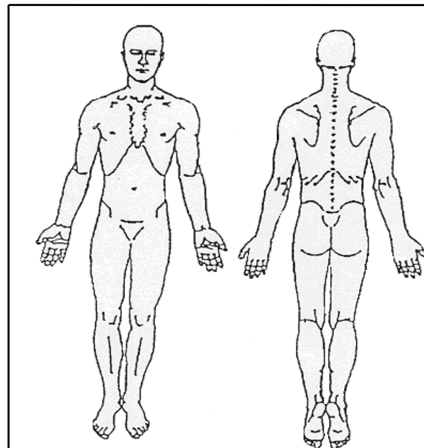
Check which apply to your symptoms: Height: _____‘ _____“ Weight:________lbs.

 Work related injury Recurrence of previous injury Injury related to falling
 Motorvehic1e accident Injury related to lifting
 Cause unknown Athletic / recreational injury Other________________________

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

	Yes	No
Diabetes		
Chest Pain / Angina		
High Blood Pressure		
Ringing in your ears		
Heart Attack		
Heart Palpitations		
Pacemaker		
Headaches		
Rheumatoid Arthritis		
Are you Pregnant		
Cancer		
Osteoporosis		
Bowel / Bladder leakage Abnormalities		
Hypoglycemia		
Asthma / Breathing Difficulties		
Recent Fractures/ Surgeries		
Smoking		
Stroke / CVA		

	Yes	No
Allergies to Aspirin		
Allergies to Heat/Cold		
Dizziness / Fainting		
Other Allergies		
Hernia		
Seizures		
Metal Implants		
Other:__ _________________________		



KEY:
Numbness = = = =
Pins & Needles 00000
Burning Pain xxxxx
Stabbing Pain //////

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

Please indicate above where your symptoms are located

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:

____
____

____
Patient/Guardian Signature **Date**