CARSON PHYSICAL THERAPY, INC.

INSURANCE DISCLAIMER

The following is an estimate from your insurance carrier. This is not a guarantee of payment.

We require that any co-payments/co-insurances be paid at the time of service. *If any additional amounts are due after all dates of service have been paid by your insurance company, a monthly statement will be sent to you.*

PRIMARY INSURANCE COMPANY: Medicaid

Benefits/Eligibility phone number: ____________________

Amount you are responsible for: $0 deductible / 0% co-insurance

As long as the patient remains Medicaid eligible, therapy will be covered at 100%. If patient becomes ineligible, charges will become the patient's responsibility.

SECONDARY INSURANCE COMPANY: N/A

Benefits/Eligibility phone number: ____________________

Amount you are responsible for: ____________________

Not applicable

TERTIARY INSURANCE COMPANY: N/A

Benefits/Eligibility phone number: ____________________

Amount you are responsible for: ____________________

Not applicable

* Approximate based on our average charge.

SIGNATURE ____________________ DATE ____________________

680 W Nye Lane Suite 205
Carson City, NV 89703
Phone: 775-882-2211 Fax: 775-882-2212

CARSON PHYSICAL THERAPY, INC.

PATIENT INFORMATION

Name ____ DOB _______________

Driver License # ________________ State ___________SS# ________________

Address ____

City _______________________________ State __________ Zip ___________

Phone (Cell) _____________ (Home) _______________ (Work) _____________

Referring Dr _____________________________ Employer _________________

Diagnosis/Body Part(s) _____________________ Date of Injury _____________

Is this injury the result of (please circle one): MVA Work Related Other Accident Gradual Onset

Emergency Contact ____

Relationship ______________________________ Phone ___________________

PATIENT COMPLIANCE AGREEMENT

I ____ understand and agree that if I no show for an appointment, I will be responsible for a $25.00 no show fee for each occurrence. This will not be covered by my insurance and will be my responsibility. In addition, after the first no show, any remaining visits will be taken off the schedule and my doctor will be notified. If cancellation for more than two appointments, any remaining visits will be dictated by the therapist.

CONSENT TO TREAT

I give permission for Carson Physical Therapy, Inc. to perform physical therapy treatment. I agree to the release of my personal health information necessary for treatment, payment and healthcare operations as stated in the privacy notice.

SIGNATURE ______________________________ DATE ___________________

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CARSON PHYSICAL THERAPY, INC.

FINANCIAL AGREEMENT

ASSIGNMENT TO PAY INSURANCE BENEFITS

I hereby assign payment directly to Carson Physical Therapy, Inc., which includes the Basis Benefit as well as Major Medical (Catastrophe) Benefits. I understand that I am financially responsible for any charges not covered by this agreement. Should the account become delinquent, I will be responsible for all reasonable costs of collection, including attorney fees. I understand that I am ultimately responsible for knowing my individual insurance coverage.

CONTRACTED VS. NON-CONTRACTED INSURANCE

Contracted Insurances: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, we will assist you in obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or denial of payment from the insurance company. **You are responsible for all charges not paid by your insurance company.**

Non-contracted Insurances: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. If we do not have a contract with your insurance, you will need to pay for the estimated office services in full at the time of service. As a courtesy, we will then submit your claim to your insurance for reimbursement to you. **You are responsible to pay any portion of the charges not covered by insurance.** If your insurance company requires a referral and/or preauthorization, we will assist you in obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

If your medical benefits have been exhausted or you have no coverage at all, **you will need to pay for office services in full at the time of service**.

SIGNATURE ______________________________ DATE ___________________

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CARSON PHYSICAL THERAPY, INC.

MEDICAL HISTORY

NAME ______________________________ DATE ________________________________

Have you received any Home Health services in the last 30 days? Yes No

If yes, what agency provided the service and when where you discharged? ____________________

____

Have you fallen in the past year? Yes No

Please check the box if you have or have had any of the following:

High Blood Pressure	☐	Headaches	☐	Hypothyroidism	☐
Low Blood Pressure	☐	Dizzy Spells	☐	History of Cancer	☐
Heart Attack	☐	Sensitive to Heat/Ice	☐	Osteoporosis	☐
Pacemaker	☐	Metal Implants	☐	OA/RA (Arthritic Conditions)	☐
Diabetes	☐	Allergies	☐	Surgeries	☐
Stroke	☐	Currently Pregnant	☐	Thyroid issues	☐
Seizures	☐	Balance Problems	☐		

Please explain and give approximate dates of any that are marked ______________________________

____

____

List of Medications if not provided separately: ______________________________________

____

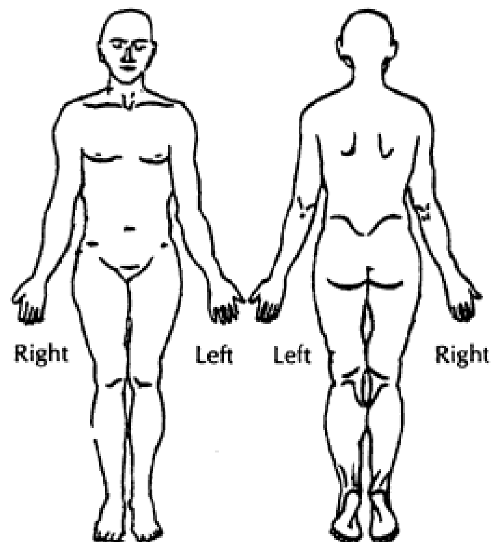
If an injury or accident, give description of incident, onset, date and areas injured. ____________________

____

____

What goals would you like to achieve in physical therapy? ________________________________

Please indicate on the body chart any area you are having pain or problems



Additional comments: ____________________

____

____

____

____

____

____

Next MD appointment? ____________________

CARSON PHYSICAL THERAPY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____

Address: ____

I have been given a copy of Carson Physical Therapy's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Carson Physical Therapy ("CPT") has the right to change this Notice at any time. I may obtain a current copy by contacting the CPT Privacy Official, or by visiting the CPT website at www.carsonpt.net.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

____ ____________________

Signature of Patient or Personal Representative Date

____

Print Name

____

Personal Representative's Title (e.g. Guardian, Health Care Power of Attorney)

______ (initial) I have elected **NOT** to take a copy of the Notice but acknowledge I have reviewed the Notice and understand how my health information is used and shared.

For Facility Use Only: Complete this section if you are unable to obtain a signature

If the patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason and describe the steps taken to obtain the patient's signature.

____

____

____

Completed by:

____ ____________________

Signature of CPT Representative Date

____

Print Name

File in patient's electronic health record

Know Your Medications – It Could Save Your Life

Medicare has a new requirement for 2015 that your healthcare professionals need a complete list of your medications, both prescriptions and over-the-counter.

In the interest of providing you and/or your family with best care, Carson Physical Therapy urges you to carry a complete, up–to-date list of your home medications with you at all times. Medication errors are a primary cause of complications in healthcare. Emergencies can occur and this information is critical for the healthcare provider to avoid adverse reactions related to medications that may be new for you during your treatment.

By using a current medication list and keeping it updated, you:

1. Reduce confusion and save time. It helps you remember your medications.
2. Improve communication. Provide health care providers with a current list of ALL of your medications. The list lets you and/or family member know exactly what medications are to be taken and when.
3. Improve MEDICATION SAFETY. Medication interactions and duplications can be detected and corrected.

In addition to prescribed medications, *it is also important to include on your list on the other side*, such things as the following:

- Eye drops
- Inhalers/Nebulizers
- Creams/Ointments
- Oxygen
- Contraceptives
- Patches that contain medication
- Over – the - counter medication: examples include Aspirin, antacids, vitamins, laxatives, etc.
- Dietary and herbal supplements: examples include Ginkgo Biloba, St. John's Wort, Green Tea, etc. (NOTE: when taking herbal supplements, please notify your physician)

We recommend your designated emergency contact person keep a current list of your home medications. This will help your health care provider to better care for you in the event of an emergency.

Please fill out the reverse side with ALL of your medications and supplements.

My Medication List

This list could save My life!

Name: ______________________

Address: ______________________

City: ________ State: ________ Zip: ________ Birthdate: ________

Emergency Contact: ______________________

Relationship: ______________________

Medical History: ______________________

____

Drug Allergies: ______________________

Physician: ______________________ Phone: ________

Specialty: ______________________

Physician: ______________________ Phone: ________

Specialty: ______________________

Physician: ______________________ Phone: ________

Specialty: ______________________

Pharmacy: ______________________ Phone: ________

Medication	Strength	How often?	Comments

Medication	Strength	How often?	Comment