

# ***CARSON PHYSICAL THERAPY, INC.***

## **PATIENTS WITH WORKER'S COMPENSATION INSURANCE**

We are interested in providing you with the best and most effective care possible. In order to begin your Physical Therapy as soon as possible, we offer you the following options:

### **NEW CLAIMS:**

Claims that have ***not yet been accepted*** by your insurance carrier require the following:

- a. Telephone authorization from your insurance company,  
Please note: this is given with the reservation that your claim is in process - it is not a guarantee of claim acceptance.
- b. **A copy of your insurance card as a back up should your claim be denied.**

### **ESTABLISHED CLAIMS:**

- a. Telephone and fax confirmation only is required.

Thank you for your patience with us in working with your insurance carrier. We make every effort to help you recover quickly and with as little hardship as possible.

### **WORKER'S COMPENSATION INSURANCE:**

NAME: \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_

CASE MANAGER - NURSE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

EMPLOYER PHONE NUMBER: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

### **PERMISSION TO PERFORM SERVICES**

I give my permission for Carson Physical Therapy, Inc. also known as Carson Physical Therapy, to perform physical therapy treatment. I also authorize the release of any medical information necessary to process this claim for insurance verification and payment.

SIGNATURE \_\_\_\_\_

### **ASSIGNMENT TO PAY INSURANCE BENEFITS (IF NOT ALREADY AUTHORIZED)**

In the event that my (*New Claim*) Worker's Insurance claim is denied, I hereby assign my health insurance company \_\_\_\_\_ to make payment directly to Carson Physical Therapy, Inc., which includes the Basis Benefits 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 costs of collections, including attorney fees.

SIGNATURE \_\_\_\_\_

**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 \_\_\_\_\_

# ***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 \_\_\_\_\_

# 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 | <input type="checkbox"/> | Headaches             | <input type="checkbox"/> | Hypothyroidism               | <input type="checkbox"/> |
| Low Blood Pressure  | <input type="checkbox"/> | Dizzy Spells          | <input type="checkbox"/> | History of Cancer            | <input type="checkbox"/> |
| Heart Attack        | <input type="checkbox"/> | Sensitive to Heat/Ice | <input type="checkbox"/> | Osteoporosis                 | <input type="checkbox"/> |
| Pacemaker           | <input type="checkbox"/> | Metal Implants        | <input type="checkbox"/> | OA/RA (Arthritic Conditions) | <input type="checkbox"/> |
| Diabetes            | <input type="checkbox"/> | Allergies             | <input type="checkbox"/> | Surgeries                    | <input type="checkbox"/> |
| Stroke              | <input type="checkbox"/> | Currently Pregnant    | <input type="checkbox"/> | Thyroid issues               | <input type="checkbox"/> |
| Seizures            | <input type="checkbox"/> | Balance Problems      | <input type="checkbox"/> |                              |                          |

Please explain and give approximate dates of any that are marked \_\_\_\_\_

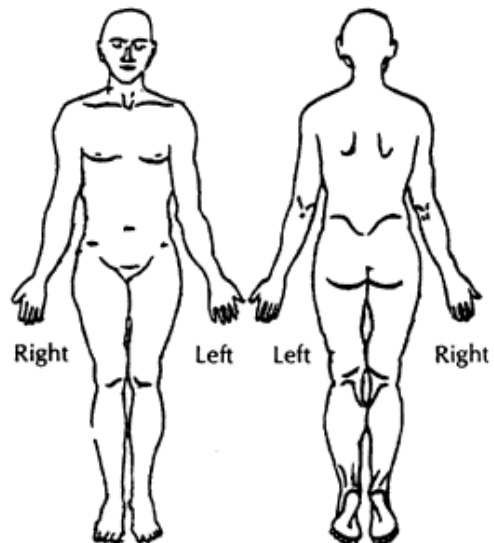
List of Medications if not provided separately: \_\_\_\_\_

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](http://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.***

