CPTE
Center for Physical Therapy and Exercise

General Information

Please fill in below and return to the front desk. If you have any questions, please feel free to ask for assistance.

Patient Full Name			
Legal Guardian (if patient is under 18)			
Home address			
City		**State**	
Zip code			

Home phone	( )
Work phone	( )
Cell Phone	( )
Date of birth (MM/DD/YY)	

CPTE uses E-mail to notify patients of upcoming appointments. With permission, we may also send you periodic informative E-mails. May we send you E-mails…

Of Appointment Reminders	*Yes/No*?
Other Informative Topics	*Yes/No*?
E-mail Address	

Health Insurance Company	
Primary care provider/physician	
Referring provider/physician	

If this is a <u>work related</u> claim, please fill in below:

Insurance company	
Case manager	
Claim no.	
Attorney (if applicable)	

If this is a <u>motor vehicle related</u> claim please fill in below:

Auto insurance co.	
Claim adjuster	
Claim No.	
Attorney (if applicable)	

If you are employed, please fill in below:

Company name			
City		State	

In case of emergency please contact	Name	
	Phone	( )

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Patient Health History

Name	
Date	
Age	

DO YOU NOW HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

	No	Yes	Date (if yes)	Details (if yes)
Diabetes				
High Blood Pressure				
Heart Disease/Attack				
Pacemaker				
Chronic Headaches				
Kidney Problems				
Nervous Disorder				
Hernia				
Allergies				
Previous surgery				
Seizures				
Osteoporosis				
Metal Implants				
Dizziness				
Cancer				

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING

Medication	Used to treat.....

GENERAL HEALTH QUESTIONS:

Question	No	Yes
Are you currently pregnant or trying to get pregnant		
Do you smoke		

LIST ANY PREVIOUS PHYSICAL OR OCCUPATIONAL THERAPY:

Treated for	Date(s)

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General Information

Patient Name	

We sincerely appreciate your input on the following which will help us serve you better

1. Have you been a patient at CPTE in the past?

☐ Yes
☐ No

2. Did your physician or health care provider suggest CPTE, or did you choose CPTE?

☐ My physician or care provider suggested or specified CPTE
☐ I chose or requested CPTE (if so, please respond to question #3 below)

3. If you chose CPTE, what influenced your decision to come to CPTE? (mark all that apply)

☐ I was a former patient and had a positive experience
☐ CPTE was recommended to me by family or a friend
☐ Information on CPTE's website
☐ Provider list from MD
☐ CPTE's general reputation in the community
☐ I used the Free Injury Assessment service
☐ CPTE's location and convenience
☐ CPTE's athletic trainer at my high school
☐ CPTE's ad in the yellow pages
☐ CPTE's ad in the newspaper
☐ Nashua Senior Activity Center
☐ My insurance provider
☐ Other _____

4. In what ways have you heard about CPTE? (mark all that apply)

☐ Provider list from MD
☐ From family or friends
☐ My physician
☐ Yellow Pages
☐ Road Sign
☐ Free Injury Assessment
☐ High School Athletic trainer program
☐ A mailing from CPTE
☐ Newspaper Ad
☐ Internet/Website
☐ Presence at an event (i.e. booth, presentation, etc.)
☐ Banner at a school or an event
☐ Nashua Senior Activity Center
☐ My insurance provider
☐ Other _____

5. Have you visited CPTE's website?

☐ No
☐ Yes

6. Is there anyone we can thank for this Referral? _____

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Consent/Billing Authorization Form

Patient Name (First name Last name)			
Legal Guardian (If patient is under 18)		**Relationship to Patient**	

CONSENT TO BE TREATED: I hereby give consent to be treated by the professional staff of CPTE Health Group, Inc. I understand that the treatment protocols used for my care are appropriate for my condition and/or injury.

BILLING AUTHORIZATION

A. **I understand** that CPTE makes every effort to verify my insurance benefits and to comply with my insurance company's requirements. I understand that the information received from my insurance company is not a promise of coverage or payment and could contain errors. I affirm and agree to assume full financial responsibility for all charges issued.

B. **I understand** that CPTE strongly suggests that I contact my insurance company and confirm my benefits and financial responsibilities for receiving any medical care.

C. **I authorize** the release of all information necessary to verify and process a claim for insurance benefits. I authorize that all payments for treatments be made directly to CPTE Health Group or its affiliates.

D. **I appoint** CPTE Health Group and its affiliates to act as my Authorized Representative with my insurance company and/or any third party involved with my course of care.

E. **I understand** that all co-pays and co-insurances are due upon check-in for my appointment(s) and all deductibles are due upon receipt of an Explanation of Benefits from my insurance company.

F. **I understand** that If CPTE has a contract with my insurance company, all terms and conditions of that contract apply.

G. **I understand** that if my account balance is past due it is subject to a finance charge of 1.5% per month (18% per year). Should my account be sent to a licensed collection agency, a 15% service charge (as allowed by New Hampshire law) will be added to my balance. All collection costs (including but not limited to attorney's fees and court costs) are my responsibility

H. **I understand** that CPTE Health Group staff may recommend that I receive certain treatment(s) and/or purchase certain items which are not covered by my insurance. I understand my therapist will not be able to inform me in advance of any such charges. I understand that it is my responsibility to know of any limitations imposed by my insurance company and that I am free to decline such services and/or suggested purchases. I understand that I will be financially responsible for these charges.

WORKMAN'S COMP AND MOTOR VEHICLE CLAIMS (only): I understand that my health insurance may require notification at the start of treatment in the event they have to provide coverage. If I choose not to provide this information I understand that my heath insurance may not accept responsibility for any past charges and I will be liable for payment.

ATTENDANCE I understand that it is my responsibility to be present at all scheduled appointments. My plan of care is designed to maximize my rehabilitation in the most efficient way possible. I understand that, should I have to cancel an appointment, I must contact CPTE as soon as possible. If I do not call to cancel, I will be considered a "No Show" and assessed a $20 fee.

_____ _____

Patient Signature **Date**

_____ _____

Legal Guardian (if patient is under 18) **Date**

CENTER FOR PHYSICAL THERAPY AND EXERCISE
CPTE-NASHUA INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (name of consumer) _____, acknowledge and agree that I have received a copy of **CPTE'S** Notice of Privacy Practices**.**

_____ _____
Consumer Signature **Date**

_____ _____
Consumer Legal Representative (if applicable) **Date**

_____ _____
Print name of Legal Representative **Relationship to consumer**

FOR CLINIC USE ONLY:

CPTE made the following good faith efforts to obtain the above- referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices: