CPTE CENTER FOR PHYSICAL THERAPY AND EXERCISE

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 and(or) text messages to notify patients of upcoming appointments. With permission, we may also send you periodic informative E-mails. May we send you E-mails/Text messages...

Permission	*Yes / No*
E-mail Address	

Primary Insurance Company	
Insurance ID#	
Subscriber of Insurance	
Relationship to patient	
Primary Care Provider (PCP)	
Referred by (if not PCP)	

Secondary Insurance Company	
Insurance ID#	
Subscriber of Insurance	
Relationship to patient	

If this is a work related claim, please fill in below:

Insurance Company	
Case Manager	
Claim No.	
Employer	

In case of Emergency, Please Contact:

Name	
Phone	
Relationship to Patient	

Notice of Privacy Practices:

☐ **I hereby acknowledge that I have been given the opportunity to read, have read, or have received a copy of the Notice of Privacy Practices from CPTE Health Group, Inc. (and its affiliates).**

I hereby grant permission for Protected Health Information (PHI) to be sent by text or voice mail to the phone number(s) I have provided. I also grant permission for PHI to be communicated to all relevant parties through standard email and text. I understand these methods are unencrypted and, in an unlikely event, may be accessible by a third party.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

Signature of Patient or Patient Representative or Guardian:
_____

Relationship to Patient: _____

Date_____/_____/_____

The following individuals have my authorization to access my Protected Health Information

Name:	Relationship:	Date of Birth:	Phone#

Consent to Treat and Consent to Bill 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:

1. **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 for all charges issued.
2. **I understand** that CPTE strongly suggests that I contact my insurance company and confirm my benefits and financial responsibilities for receiving any medical care.
3. **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 it's affiliates.
4. **I appoint** CPTE Health Group and it's affiliates to act as my Authorized Representative with my insurance company and/ or any third party involved with my course of care.
5. **I understand** that all co-pays and co-insurances are due upon check-in for appointment(s) and all deductibles are due upon receipt of an Explanation of Benefits from my insurance company.
6. **I understand** that if CPTE has a contract with my insurance company, all terms and conditions of that contract apply.
7. **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 attorneys' fees and court costs) are my responsibility.
8. **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 health insurance may not accept responsibility for any past changes 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**

Patient Health History:

Patient Name: **Date:**

Date of Birth: **Therapist:**(If a returning patient)

Have you ever been diagnosed with any of the following conditions (check all that apply)?

	Conditions/ Problems	**Please define if appropriate:**
	Allergies	
	Anemia	
	Anxiety	
	Arthritis (Type)	
	Asthma	
	Cancer (Specify)	
	Chemical Dependency: ie: Alcoholism	
	Depression	
	Diabetes	
	Endocrine (Thyroid) Problems	
	Epilepsy	
	GI Problems	
	Heart Disease	
	High Blood Pressure	
	Kidney/ Liver Problems	
	Lung Problems	
	Multiples Sclerosis	
	Osteopenia/ Osteoporosis	
	Pacemaker	
	Parkinson's Desease	
	Stroke	
	Surgeries	
	Other	

General	**No**	**Yes**	**Detail**
Are you currently pregnant or think you might be pregnant?			
Do you smoke?			
Do you have metal implants?			
Occupation			Work Duties:

Please list any medications or give receptionist medication list to scan into system:

Medication	**Dose**	**Medication**	**Dose**

Patient Input:

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 refer you directly to 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. **Why did you chose CPTE?**_____

4. **In what ways have you heard about CPTE? (mark all that apply)**
   ☐ Provider list from MD
   ☐ From family or friends
   ☐ My physician
   ☐ 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
   ☐ Facebook
   ☐ My insurance provider
   ☐ Senior Center Screenings
   ☐ Other _____

5. **Is there a family member or friend that we can thank for this referral?**_____

6. **Have you visited CPTE's website? (www.cpte.net)**
   ☐ Yes
   ☐ No