PATIENT INFORMATION

First Name: ____________________________ (MI) ____ Last Name: ________________________________

Birth date: __________ Age: ________ Social Security #: ___________________

Sex: () M () F   Marital Status: () S () M () W () D

Address: ______________________________City: ____________________ State: ______ Zip: ________

Phone #: ________________   Alternate Phone # ___________________, Cell phone carrier?___________

Employer: ___________________________________   Work #: _____________________________

Referring Physician: _____________________   Primary Physician: ___________________________

Are you allergic to any medication? ____________________ How did you hear about us? ________________

Email address: _____________________ Prefer method of appointment confirmation: Text- email- voice message

EMERGENCY CONTACT

Name: ________________________________ Relationship to Patient: ____________________________

Phone #: ____

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

I hereby give my consent to perform rehabilitation therapy as prescribed by my physician in an Outpatient facility. I authorize any holder of medical and/or other information pertaining to my condition to release it to Complete Therapy USA Inc.

______________________________   _______________________

Patient Signature   Date

ASSIGNMENT OF INSURACE BENEFITS-TREATMENT/CHARGES EXPLANATION

I hereby request that my insurance carrier make payment to Complete Therapy USA Inc. for any and all services rendered to me. I, the undersigned understand that the center will bill my insurance company. I also understand that should my insurance company fail to render payment for the services received, I am fully responsible for the payments of any and all deductible and or co-insurance amounts, and that charges incurred are not subject to any payments by my insurance company. Should it become necessary for the Complete Therapy USA Inc. to engage professional collection efforts, I will be held responsible for any and additional costs of collection, including but not limited to: agency fees, attorney's fee and interest.

______________________________   _______________________

Patient Signature   Date

COMPLETE THERAPY USA AND YOUR INSURANCE PLAN- HOW THEY WORK TOGETHER

The staff at Complete Therapy USA is pleased that you have insurance benefits to help with the cost of your medical care. We would like to help you obtain the maximum use of these benefits. Please read the information on our insurance claims process so that we can work together to ensure these benefits.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept most insurance plans; this means that we work with hundreds of companies. Although we can maintain computerized histories or payments by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?

We base the patient portion of your bill on our most current data but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment at another office prior to joining the Complete Therapy USA family, which is not calculated in our database. Sometimes you may need to see a specialist for care, which also uses your annual benefits. Insurance companies do not and cannot in most cases notify us of changes to your benefits, they only notify **YOU**. If these circumstances apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DIDN'T PAY. NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 60 days, Complete Therapy USA reserves the right to request payment in full for your services from you and let you collect the reimbursement funds from your insurance that are due to you. This is rare, but it is important that you recognize that your health plan is a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. X___________ (initials)

FINANCIAL OPTIONS

Complete Therapy USA does request payment in full for your portion at the time of service. We accept Visa, Mastercard, AMEX, and Personal Checks. If you need an extended finance option, we also work with CareCredit, which offers a 12 month "same as cash" or longer terms with a low interest-bearing revolving charge designed to meet your treatment plan needs. Feel free to ask one of the patient services staff members for more information.

We welcome you to our family and look forward to helping you better your health and feel better. If there is anything, we can do to make your visits more pleasant, please don't hesitate to ask one of our staff members.

I have read, understood, and accept the terms of the above outlined policies for insurance handling and financial commitments that I can incur because of treatment at Complete Therapy USA.

____ ____________________

Signature **Date**

Patient name: ______________________ Date: _________

Present Illness:

For what condition or symptoms are you being seen for at this time?

When did this condition begin?

Have you been involved in an Auto accident or work injury?

What treatment have you already received?

Has this problem occurred in the past?

Past Medical History:

Please indicate whether you or your family member has had the following conditions:

	You	Family
Cancer		
Heart Disease		
Arthritis		
High Blood Pressure		
Bleeding Tendency		
Diabetes		
Stroke		
Gout		
Epilepsy		
Kidney or Bladder Problems		
Respiratory Disease		
Pneumonia /Emphysema		
Hepatitis		
Asthma		
Jaundice		
Hernia		
Thyroid Disorder		
Congenital Disorder		

Are you pregnant? Yes No
Do you have a pacemaker? Yes No
Do you have any surgical implants? Yes No
Have you fallen in the past year? Yes No If yes, how many times________

2627 NE 203 ST. Suite #110
Aventura, Florida, 33180
PHONE: 466-1388/ FAX: (305)466-9200

Please list all surgeries, including approximate dates:

Please list any procedures, fractures, or serious injuries (including previous car accidents with injuries):

Please list any allergies (including medications, latex, topical ointments, iodine foods, etc.):

Please list all medications and indicate for what condition they are being taken:

Please provide us with all information about your insurance coverage at the time of the first visit to our office.

We wish to stress that the financial responsibility for the services rendered rests with the patient or their family, regardless of any insurance coverage. Remember that very few insurance policies pay 100% of bills submitted. Please review your individual policy concerning physical therapy coverage.

In cases where the financial coverage for your care is being handled through an attorney, we must have a lien form signed by both the attorney and the patient. For treatment to continue uninterrupted, this form must be completed in a reasonable time. In those legally involved cases due to long payment delay, a 1.6% monthly interest charge will be added.

Patient medical information to insurance companies, attorneys, etc., will not be given over the telephone under any circumstances. This is for your protection. In order to release any information, we must have a release signed by the patient, indicating to whom we may release information.

______________________________ ______________

Patient Signature Date

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I, ______________________________________ have read and acknowledged the HIPPA notice of privacy practices at this office.

_______________________ _______________________

Patient Signature Date

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Cancellations and No Show No Call Policy

The following is our policy regarding cancellations and no-shows. We take this subject seriously. Showing up as scheduled for these visits is essential.

We require 24 hours notice in the event of a cancellation. It is your responsibility to have a time in mind to reschedule your appointment.

There is a **$25.00 charge** for a cancellation without proper notice or for a no-show.

Please cooperate with us regarding this matter; we are looking forward to treating you. Thank You.

______________________________	______________________________
Patient Signature	**Date**