Central Mountain Physical Therapy, Inc
Patient Information Form

Patient #_______Previous CMPT pt: ___________

Name____
(Last) (Middle) (First)

Address: (Need Physical Street) ____________

____

__________ _____ _________
(City) (State) (Zip Code)

Phone (____) _____-_________

Work (____) _____-___________

Cell (___) _____-______________

E-mail:_______________________

Date of Birth___/___/____

Social Security #______-____-______

Referring MD: __________________

Date Last Seen: _________________

Diagnosis: ____________________

Date of Injury/Surgery : ___________

Primary MD: ___________________

Eval Date/Time: ________________

Primary Insurance _______________________ ID # of policyholder:_________________

Name of Policy Holder: ____________________ Relationship to Insured: ______________

Soc Sec # of Policy Holder: ________________ DOB: __________

Secondary Insurance ____________________ ID # _______________________

W.C./Auto: Employer/Company_____________________________ **(Note: Still Need To Obtain Primary Insurance Info if WC)**

Phone #: ________________________

Claim #: _________________________ **Contact Person/HR:** ___________________________

Emergency Contact: _______________________ Relationship: _______________________

Home Phone: _____________________Work Phone: _____________________ Cell :______________

Name of your Employer/School: ________________________________ Full Time____ Part Time ____

Chiropractic Care/Physical Therapy (this year): ___Yes ____No How Many Visits: ________

(Note: should you receive simultaneous services it may go against any authorized PT visits and your insurance may not cover your services in full)

Hospitalized: ___Yes ____No If Yes, from _____ To_____

Out of Work: ____Yes ____ No If Yes, From_______ To_____

Have you received any Home Health Services within the past year? ______

Where: ____________________________ Discharge Date: ___________ Confirmed D/C Date: ___________

Please Read

CONSENT TO TREATMENT

THE UNDERSIGNED HAS REQUESTED TREATMENT CONSIDERED NECESSARY FOR THE PATIENT WHOSE NAME APPEARS ON THE TOP HEREOF AND THAT THE TREATMENT AND PRODECURE WILL BE PERFORMED BY A LICENSED PHYSICAL THERAPIST AND EMPLOYEES OF CENTRAL MOUNTAIN PHYSICAL THERAPY. AUTHORIZATION IS HEREBY GRANTED FOR SUCH TREATMENT AND PROCEDURES.

________________ ________________________________ ________________________

Date Signature Witness

Because the patient is an unemancipated minor, ____ years of age, or is unable to sign for the following reasons:

____

________________ ________________________________ ________________________

Date Signature Witness

AUTHORIZATION FOR RELEASE OF DIAGNOSTIC AND/OR PROCEDURE INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF DIAGNOSES AND PROCEDURE(S) INFORMATION TO MY INSURANCE COMPANY/COMPANIES SOLEY FOR THE PURPOSE OF BILLING THIS CLAIM, AND ASSIGN INSURANCE BENEFITS DIRECTLY TO CENTRAL MOUNTAIN PHYSICAL THERAPY, INC.

________________ ________________________________ ________________________

Date Signature Witness

Financial Responsibility: (Please Talk to Office Manager regarding your copay/deductible payment options)

I certify that the information I have provided regarding my insurance coverage is correct and authorize CMPT, Inc. to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies. I agree to pay any copayments, coinsurance, or deductible as required by my insurance plan for medical care provided to me or my dependent. I agree to pay for medical services provided to me or my dependent that are not covered by the benefits in my insurance plan. I understand that I am ultimately responsible for knowing the terms and regulations of my insurance plan. I agree to accept full responsibility for payment if my insurance coverage is not verified or I exceed PT authorized visits (especially if I fail to notify CMPT office staff of simultaneous physician or chiropractic services). CMPT, Inc may impose reasonable interest, late charges, direct collection agency costs or reasonable attorney's fee should my account become delinquent. I agree to the above stated Responsibility and Consent.

________________ ________________________________ ________________________

Date Signature Witness

The Following Box applies to Medicare Patients Only

I request that payment of authorized **MEDIGAP** benefits be made either to me or on my behalf to Central Mountain Physical Therapy, Inc (CMPT) for any outpatient physical therapy services furnished to me by CMPT. I authorize any holder of Medicare information about me to be release to **(Name of your Supplemental Insurance)**_________________ and any other information needed to determine these benefits payable for the related outpatient physical therapy services.

******** Note: Have you changed your supplemental/secondary insurance within the past year? ________; If yes, have you notified Medicare of this change so Medigap forwards your payment information to the correct supplemental insurance company? ______; if no, please call the Medicare phone number found on your insurance card.**

Signature________________________________ Date_________________