

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

Patient Name (First name Last name)			
Legal Guardian (if patient is less than 18)			
Home address			
City		State	
Zip code			

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

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

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

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

If this is a motor vehicle related 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	()

Is there anyone we can thank for this referral	
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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 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 forDate(s)

Patient Name	
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We sincerely appreciated 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

Legal Guardian 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

Other _____

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

From family or friends

My physician

Yellow Pages

Road Sign

Free Injury Assessment

Provider list from MD

High School Athletic trainer program

A mailing from CPTE

Yellow pages

Newspaper Ad

Internet/Website

Presence at an event (i.e. booth, presentation, etc.)

Banner at a school or an event

Other _____

5. Have you visited CPTE's website?

No

Yes, once

Yes, more than once

Patient Name (First name Last name)	
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Legal Guardian (If patient is under 18)		Relationship to Patient
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Please initial in each section below:

_____ **CONSENT TO BE TREATED** I hereby give consent to be treated by the physical therapy staff of CPTE Health Group, Inc. I understand that the treatment protocols used for my physical therapy are appropriate for my condition or injury.

_____ **BILLING AUTHORIZATION**

I authorize release of all information necessary to verify and process a claim for insurance benefits. I further irrevocably authorize that all payments for treatments be made directly to CPTE Health Group, Inc. **In addition, I understand and agree to assume full financial responsibility for all charges issued.**

All co-pays and co-insurances are due upon check-in for your appointment.

If CPTE has a contract with your insurance company, all terms and conditions of that contract apply. If CPTE does not have a contract with your insurance company, **CPTE is not bound to the terms and conditions of your policy.**

Accounts 90 days and over are subject to a finance charge of 1.5% per month (annual percentage of 18%). Should this account be sent to a licensed collection agency, a 15% service charge (as allowed by New Hampshire law) will be added to your balance. All collection costs (including but not limited to) attorney's fees and court costs are the patient's responsibility

CPTE may recommend that you purchase certain items to facilitate your rehabilitation which are not covered by your insurance. If purchased, your payment is required at time of delivery. You are free to decline to purchase these items.

_____ **WORKMAN'S COMP AND MOTOR VEHICLE CLAIMS (only)** I understand that my health insurance requires 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 will not be responsible for any past charges and I will be liable for payment.

_____ **ATTENDANCE** It is the responsibility of the patient to be present at all scheduled appointments. The plan of care is designed to maximize your rehabilitation. Please contact us as soon as possible to cancel appointments. If you do not call before your scheduled appointment time, you will be considered a "No Show" and assessed a \$20 fee that is not billable to your insurance company.

Patient Signature

Date

Legal Guardian (if patient is under 18)
Must be signed in person at CPTE

Date

102709 V3

General Information

General Information

Patient Health History

Consent/Billing Authorization Form