CONNECTICUT PHYSICAL THERAPY SPECIALISTS

11 MILL POND DRIVE, GRANBY, CT
342 NORTH MAIN ST., WEST HARTFORD, CT
60 VILLAGE PLACE, GLASTONBURY, CT

DATE: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Body Part(s): _____

Date of Birth: _____ Injury Date: _____

Surgery: **YES** OR **NO** If yes, Date (s): _____ Previous PT this year?: **YES** OR **NO**

Auto Accident: **YES** OR **NO** Work Related: **YES** OR **NO** Other: **YES** OR **NO**

How did you hear about us: (Ex. internet, walk-in, friend, etc.)_____

PATIENT CONTACT INFORMATION

Address: _____

City: _____ State: _____ Zip: _____

Home # : _____ Cell #: _____ Work #: _____

Email: _____

Emergency Contact: _____

Emergency Phone#:_____ Contact Relationship: _____

Reminder Option (please circle): **TEXT** OR **CALL**

Employer: _____

Occupation: _____

REFERRAL DOCTOR OR PRIMARY CARE DOCTOR:

Ref MD: _____ Ref MD Grp: _____

Ref MD Phn: _____ Ref MD City/State: _____

PCP MD: _____ PCP MD Grp: _____

PCP MD Phn: _____ PCP MD City/State: _____

Patient Signature : _____ **Date**: _____

(Parent or guardian if under 18)

INSURANCE / BENEFITS INFORMATION

PRIMARY INSURANCE (Check here ☐ if card has been scanned by front desk staff):

Company Name: _____ ID #: _____

Group #: _____ Employer: _____

SUBSCRIBER INFORMATION (Check here ☐ if same as patient):

First Name: _____ Last Name: _____

DOB: _____ Relation: _____

Address: _____

City/State/Zip: _____

SECONDARY INSURANCE:

Company Name: _____ ID #: _____

Group #: _____ Employer: _____

WORK COMP INFORMATION OR MED-PAY/AUTO INFORMATION:

Company Name: _____ Work Location _____

Claims Address: _____

Claim #: _____ Adjuster Name: _____

Adj Phn: _____ Adj Fax: _____

ATTORNEY INFORMATION:

Attny Name: _____ Attny Firm: _____

Attny Phn: _____ Attny Fax: _____

Attny City/State: _____ Auto Med-Pay: **YES** OR **NO**

Patient Signature : _____ **Date**: _____

(Parent or guardian if under 18)

DISCLOSURE

I, the above patient, parent or legal guardian of patient, policyholder, or claimant as applicable hereby contract with Connecticut Physical Therapy Specialists, LLC (CTPTS) to render physical therapy as prescribed by my physical therapist and/or my referring physician. I understand and agree that CTPTS will first seek reimbursement from my insurers and I direct my insurance to pay all benefits or coverage to which I am entitled to CTPTS and I hereby assign any benefits or coverage to which I am entitled to CTPTS for their services. I understand and agree I am responsible for all co-pays, co-insurance, deductibles or any fee, charge or service my insurer does not pay. If an insurer reimburses me directly, or my portion of a settlement, I will immediately remit to CTPTS the share of reimbursement they are entitled for their services. If I have no insurance I understand and agree I am responsible for all fees, charges or services rendered by CTPTS.

I agree that any bill to me by CTPTS is to be paid in full within thirty (30) days of the date of said bill and that any unpaid balance may be assessed a one percent per month (1% / mo.) late fee. I further agree that if CTPTS has to refer my unpaid bill to an attorney for collection I agree to pay reasonable attorney fees.

I authorize CTPTS to release any and all medical information concerning my treatment to my physician or attorney upon written request from myself or the physician or attorney.

Signature: _____ **Date**: _____

CTPTS Staff: _____ **Date:** _____

CANCELLATION/NO SHOW POLICY

We value your time as our patient. We hope that you will also value the time of our therapists by calling our office if there is a reason you are unable to keep your appointment. Keep in mind that it has been proven that consistent attendance provides for the greatest opportunity for success. With that said, **We request 24 hours notice for cancellations**. Being more than **10 min late** may require cancellation and rescheduling. We understand that circumstances arise that prevent you from attending your appointment. These cases will be weighed on an individual basis and treated appropriately. While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Chronic cancellations, regardless of the 24 hour notice, will be charged accordingly. These fees are not covered by traditional/commercial health insurance and are the responsibility of the patient. Patients will receive telephone/text reminders of appointment dates/times the day prior to their scheduled appointment (unless patient chooses not to be notified). Patients will always be provided copies of their scheduled appointments as requested as well.

Cancellation Charge without 24 hour notice: $25.00

No-Show Charge: $50.00

For those individuals involved in a legal case (**Motor Vehicle Accident MVA**) with an attorney that have been issued a letter of protection to cover the cost of their care - these fees come out of your portion of the final settlement.

For individuals whose cost of care is being covered by **Worker's Compensation** - Attending your appointment(s) needs to have the same consideration as showing up to work. Your attorney (if you have one involved), adjuster and employer have access to your treatment notes as well as a listing of cancelled and missed appointments.

Patient Initials: _____ **CTPTS Initials:** _____

GENERAL INFORMATION

You, the policy holder, are ultimately responsible for knowing your benefit coverage, including the authorization process, copays, deductibles and visit maximums. We at CTPTS do our very best to verify and explain your coverage based on information made available to us via your insurance company.

It is **STRONGLY** suggested that children who require supervision do not attend therapy sessions with a patient.

ANY insurance change needs to be communicated to CTPTS as soon as possible to avoid possible increased charges.

Please **limit cell phone use to emergencies only** during your treatment session.

CONSENT TO TREAT

I, the undersigned, voluntarily consent to the evaluation and treatment by the clinicians of Connecticut Physical Therapy Specialists. The physical therapist will explain the nature and purpose of the course of treatment as well as the expected benefits or possible discomforts that may arise. The therapist will also discuss alternatives to the proposed treatment, where appropriate, and the risk and consequences of no treatment. It is your right to decline any part of your treatment at any time.

STATEMENT OF PRIVACY NOTICE

We may disclose your health care information to your insurance provider or to other healthcare professionals for the purpose of treatment, payment or healthcare operations. We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death. We may disclose your health information for military, national security, prisoner and government benefits purposes. We may leave a message on an automated answering device or person answering the phone for purposes of scheduling appointments. In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner. You have the following rights: to request restrictions on certain uses and disclosures of your health information although we are not required to oblige; to have your health information received or communicated in a format other than the usual method; have the right to inspect and copy your health information; have the right to amend your health information, however, we are not required to agree to amend; and have the right to receive an accounting of who we've shared your health information with. We are required by law to maintain the privacy of your health information. Complaints about your privacy rights should be directed to the Office Manager of CTPTS (Janet Mansfield, 860-999-1859). Formal complaints can be submitted to DHHS, Office of Civil Rights. By way of my signature on this form, I provide CTPTS with my authorization and consent to use and disclose my health information in the manner as stated above.

Our system will be sending you an email with a link to a one question survey. We would appreciate your feedback.

Patient Printed Name : _____

Patient Signature: _____ **Date:** _____

(parent or guardian if not 18)

CTPTS Staff: _____ **Date:** _____

CONNECTICUT PHYSICAL THERAPY SPECIALISTS

10 YEAR ANNIVERSARY

Check here ☐ if you're currently not taking any medication:

CURRENT MEDICATION LIST

DRUG NAME	DOSAGE	FREQUENCY	PRESCRIBING MD	ROUTE: P.O = By Mouth INJ = Injection S = Skin/Topical

LOCATIONS:

11 MILL POND DRIVE, GRANBY, CT 06035 // 860-413-9969

342 NORTH MAIN STREET, SUITE# 150 WEST HARTFORD, CT 06117 // 860-461-7940

60 VILLAGE PLACE, GLASTONBURY, CT 06033 // 860-999-1859

CTPTS FAX // 860-288-5511