COMPLETE PHYSICAL THERAPY CENTERS OF GEORGIA

PATIENT INFORMATION

DATE OF BIRTH ______________________ AGE ____________ SSN _______________________ SEX: ☐ MALE ☐ FEMALE

TITLE _________ FIRST NAME_________________________ MI ________ LAST NAME _______________________________

ADDRESS ____ CITY _________________ STATE ______ ZIP CODE___________

PRIMARY PH. _______________________________________ SECONDARY PH. _______________________________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ PREFER NOT TO DISCLOSE

SPOUSE'S NAME __________________________ PRIMARY PH. _________________ SECONDARY PH. __________________

PATIENT'S EMPLOYER ______________________________________ OCCUPATION ________________________________

EMPLOYER ADDRESS ____ EMPLOYER PH. ______________________________

EMERGENCY CONTACT NOT LIVING WITH YOU ____________________________ PRIMARY PH. ____________________

ADDRESS _______________________________________ CITY _________________ STATE _________ ZIP CODE __________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY __________________________________ SUBSCRIBER NAME _______________________

SUBSCRIBER RELATIONSHIP ______________ SUBSCRIBER DOB ___________ SUBSCRIBER SSN ____________________

SECONDARY INSURANCE COMPANY ______________________________ SUBSCRIBER NAME _______________________

SUBSCRIBER RELATIONSHIP ______________ SUBSCRIBER DOB ___________ SUBSCRIBER SSN ____________________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

TITLE _________ FIRST NAME _________________________ MI ________ LAST NAME _____________________________

ADDRESS ____ CITY _________________ STATE ______ ZIP CODE___________

DATE OF BIRTH ______________________ SSN _______________________ PRIMARY PH _____________________________

EMPLOYER ____ EMPLOYER PH ____________________________________

SIGNATURE OF PATIENT/RESPONSIBLE PARTY ____ DATE ______________

TO ENSURE YOUR PRIVACY, PLEASE ANSWER THE FOLLOWING QUESTIONS AND NOTIFY THE FRONT OFFICE STAFF OF ANY CHANGES.

1. DO WE HAVE PERMISSION TO LEAVE A MESSAGE ON THE PHONE NUMBER(S) YOU HAVE PROVIDED TO US?

   YES ☐ OR NO ☐

2. MAY WE DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY AND FRIENDS?

   YES ☐ OR NO ☐

****IF YES, PLEASE LIST NAMESOF PEOPLE WE CAN DISCUSS YOUR MEDICAL CARE WITH:*

NAME: ______________________________ PHONE: _________________________

RELATIONSHIP: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ FRIEND

NAME: ______________________________ PHONE: _________________________

RELATIONSHIP: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ FRIEND

NAME: ______________________________ PHONE: _________________________

RELATIONSHIP: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ FRIEND

3. IF SOMEONE CALLS FOR YOU OR ASKS FOR YOU WHILE YOU ARE IN OUR OFFICE, DO WE HAVE PERMISSION TO TELL THEM YOU ARE HERE?

   YES ☐ OR NO ☐

________________________________ ________________________________

PATIENT SIGNATURE DATE

COMPLETE PHYSICAL THERAPY CENTERS OF GEORGIA

NAME: ____ DOB: ___________________________

PATIENT CONSENT

INSURANCE: We will file your claims; however, the services are rendered and charged to you. This is your responsibility and obligation. All co-pays are due at the time of each visit, unless otherwise arranged with our office staff. We will verify that you have benefits for Complete Physical Therapy, but this is not a guarantee of payment from them. We will attempt to get any referrals from your insurance company if necessary, but it is your responsibility to make sure they are received. I allow Complete Physical Therapy Centers of Georgia to give information related to me to any third party payer, insurance company, or parties hired by these payers which may be responsible in whole or part for paying my bill, to monitor utilization of rehabilitation services, or to any healthcare facility or physician in which I am referred. I hereby assign all benefits directly to Complete Physical Therapy Centers of Georgia and also authorize release of medical records to process medical claims. **_______ INITIAL**

CONSENT TO TREAT: I CONSENT TO REHABILITATION AND THE INCIDENTAL MEDICAL SERVICES AT COMPLETE PHYSICAL THERAPY CENTERS OF GEORGIA. **_______ INITIAL**

PAYMENT POLICY

It is our policy to collect <u>all</u> co-pays, coinsurances, deductibles, and balances at time of service. For payment arrangements please speak with our billing office. **_______ INITIAL**

APPOINTMENT POLICIES

We understand that unplanned issues may arise and you may not be able to make it to your appointment on time. If that happens, we respectfully ask that you notify our office. If you arrive after your scheduled time, you may be asked to wait for a break in the schedule or reschedule for a later time or date. **_______ INITIAL**

To ensure you and all of our patients have access to convenient, quality care, please notify us at least 24 hours in advance if you need to cancel your appointment. **If you are not able to keep your scheduled appointment time and you do not give us a 24-hour notice, you will be charged a $35.00 missed appointment fee.** **Please note that the $35.00 fee is not covered by your insurance and does not apply to your deductible or out-of-pocket maximum. Fees are applied ten minutes after your scheduled appointment time.* **_______ INITIAL**

____ _____________________________

Signature of Patient or Guardian Date

____ _____________________________

Signature of Office Staff/Witness Date