CP PHYSICAL THERAPY
CHRIS PETERSEN, DPT

Patient information

Last Name _____First Name _____ MI _____

Mailing Address_____

City_____ State _____ Zip _____

Email Address _____

Home Phone (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Date of Birth ____/____/_____ SSN _____ Gender _____ Marital Status _____

Emergency Contact

Last Name _____ First Name _____

Relationship _____ Phone (_____) _____-_____

Employer

Name_____ Phone (_____) _____-_____

Address_____

City _____ State _____ Zip _____

Problem

Problem Area _____ Date of Injury/Onset _____ Last MD visit _____

Referred by _____ Primary Care Physician _____

Primary Insurance

Carrier _____ ID # _____ Group #_____

Subscriber Name _____SS#_____ _____ DOB _____

Secondary Insurance

Carrier _____ ID # _____ Group #_____

Subscriber Name _____SS#_____ _____ DOB _____

Authorization to treat, release information and assignment of insurance benefits

I hereby authorize CP Physical Therapy to evaluate and treat me (or my dependent). I authorize CP Physical Therapy to release to my insurance company(ies) any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at CP Physical Therapy. I hereby agree to full responsibility for all expenses incurred by myself, or minor child.

Initials: _____

Financial policy and agreement

1. Insurance co-payments are required at check-in. We accept most major credit cards, cash and check.
2. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and any changes to your insurance. Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claims. You are responsible for knowing what your insurance does or does not cover and the providers and network(s) covered by your insurance company. You will be billed for any service provided, but not covered by your insurance company.

Initials: _____

Notice of privacy practices acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information.

Other parties whom you would like to receive information on your behalf (not insurance companies):

_____

Initials: _____

Message authorization

I authorize CP Physical Therapy to leave detailed information on my phone: Cell: Y / N Home: Y / N

Initials: _____

I have read and acknowledge the above statements with my signature below.

Signature:_____ Date:_____