COMMERCIAL INSURANCE
Patient & Payor Information Form
***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (____) _____-_____ Home (____) _____-_____ Mobile (____) _____-_____ Work (____) _____-_____ Emergency

(2) Patient **Sex: M F** **Birthdate:** ____/____/____

S.S # ____/____/____ **Legal Photo ID #** _____
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy: _____

Date Condition Began? Date:____/____/____

Is it Related to an Auto Accident? No Yes Date of Accident ____/____/____

Is it Non-Work Related Accident? No Yes Date of Accident ____/____/____

Did this Condition Result in Surgery? No Yes If Yes Date of Surgery ____/____/____

Have You Had PT for this Condition? No Yes If Yes Where?_____

Have You Had Chiropractic Services for this Condition? No Yes If Yes Where?_____

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

Referring Dr's Name: Last First Initial MD, DO, DDS, Other **Office Phone:** (____) _____-_____

Address: Street City,State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

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(5) If Filing Insurance : Check A or B

A. ____ Patient is the insured (Do not need to complete the rest of #5 or any of #6)

B. ____ Insured is ___Spouse ____Parent (Complete all of #5 and all of #6)

Name: Last First Initial Sr./Jr.

Address: Street Apt.# City State Zip Code

Phone: (___) ___-____ Home (___) ___-____ Mobile (___) ___-____ Work (___) ___-____ Emergency

(6) Insured Person:

Complete if not the patient

Date of Birth: ____/____/____ **S.S. #** _____/_____/_____

Legal ID # _____ **Insured's Sex: M F**

___ **Employed** ___ **Unemployed** ___ **Retired**

(7) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: _____ **Employer Phone # (** **)** _____-_____

Address: _____
Street City State Zip Code

Name of Employer Contact: _____ **Contact's Phone # (** **)** _____-_____

(8) Payor Information:

Primary Insurance Company:

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph #**_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Secondary Insurance Company: (If YES, please complete) **Insured is: _____Patient _____Spouse _____Parent**

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph#**_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ **Employer Phone # (** **)** _____-_____

Address: _____
Street City State Zip Code

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(9) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

(10) Payment Authorization: ***(Initials required for all 3 statements)***

_____ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to *FACILITYNAME for all services delivered; if I am paid directly I will promptly pay *FACILITYNAME all monies paid to me**

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer by the statement due date**

_____ **Certification of Information**

Initials **I certify that the information I have provided *FACILITYNAME for payment including, but not limited to, Related accidents, illnesses or other insurers is accurate and truthful**

(11) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

Informed Consent for Therapy Services

"Informed Consent" is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

Potential Benefits. You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaint. Many times, increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion, our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in you therapy program, you will be asked to consult with our physician about other treatment alternatives.

No Warranty: Please not that we cannot make any promises or guarantees regarding a full resolution of and/or correction of you condition. We will, however, work in conjunction with you to achieve optimal improvement.

_____initials

PAYMENT AUTHORIZATION

Assignment of Insurance Benefits

I authorize that the payment of my insurance benefits be made directly to CTI for any services that are reimbursable by my insurance, including, but not limited to Medicare, Medicaid, TriCare, TriWest (VA), and private insurers.

Guarantee of Payment

I understand that all payments designated as "the patient's responsibility" are due and payable at the time of service or billing. I guarantee that I will pays:

1. My designated portion including co-pays/co-insurance and my deductible,
2. All amounts due for services that my insurance company has stated are not covered benefits (if I have been advised by CTI in advance of the service delivery and have authorized it in writing),
3. All amounts due for services billed by CTI but paid directly to me,
4. All amounts due for services billed by CTI to a Workers' Compensation payer which was subsequently declared by my employer to be a non-eligible claim, and
5. All amounts due for claims submitted by CTI to my insurance company and not paid by 60 days.

Medicare and Workers Compensation Information

I certify that the information I have provided to CTI for payment under the Social Security Act (Medicare) or under the Workers' Compensation Program is correct, including, but not limited to, any related accidents/illness or other insurers/payers available.

_____ Initials

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING

I have been given and have read the following documents:

1. **Payment Authorization**
   - By signing below, I understand the statements of this authorization and declare their truthfulness.

2. **Cancellation and No-Show Policy**
   - By signing below, I understand and agree to comply with CTI's cancellation and no-show policy.

3. **Informed Consent for Therapy Services**
   - By signing below, I acknowledge I have read the Informed Consent document and I consent to the evaluation(s) and treatment provided by CTI.

4. **Authorization for Release of Information** (initial one of the following)

   _____I do NOT authorize CTI to release my protected health information other than for treatment or payment.

   _____I authorize CTI to release my protected health information as indicated on the completed Authorization for Release of Information form.

5. **Patient/ Client Rights & Responsibilities**

6. **Notice of Privacy Practices**
   - My signature below indicates that I have been given the Notice of Privacy Practices for CTI. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations, or as permitted or required by law, I must give my written authorization to CTI to release any of my protected healthcare information.

I have received and read the notices outlined above, and have been given an opportunity to ask any questions I may have regarding these documents. By signing below, I acknowledge that I understand each form and its intent.

_____ _____

Patient's or Authorized Representative's Printed Name Date

_____ _____

Patient's or Authorized Representative's Signature Initials

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

(1) **Patient's Printed Name**:

_____
Last First Initial or Other

Date of Birth: ____/____/___ Insurance # exactly as on card (including letters)_____

(2) CTI will only disclose the protected health information you want disclosed.
Check only one box to tell CTI the specific information you want disclosed/released:

☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)

☐ Limited information (complete ALL Sections)

☐ ALL records regarding my care at CTI to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination _____ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History _____ Treatments _____ Other _____

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ Other: _____

(5) Check only one box indicating how long CTI can use this authorization:

☐ Disclose my information indefinitely (as long as CTI has custody of my files)

☐ Disclose my PHI for the following period beginning ___/___/_____ and ending ___/___/_____

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_____ I understand that this authorization does not expire unless I have indicated an expiration date above
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_____ I understand that if I give authorization I may revoke it at any time by notifying this CTI in writing
_____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_____ I understand that if CTI requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_____ CTI will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

_____ **or** _____

Signature of Patient **Date** **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**

You May Refuse to Sign this Authorization

COMMUNITY
THERAPIES

100 E. Manana Blvd, Unit 1, Clovis, NM 88101
(575) 366-5014
Fax (575) 366-5015

COMMUNITY
THERAPIES

Dear Patients,

Due to high incidence of unexpected cancellations or no-shows, Community Therapies (CTI) has found it necessary to implement a cancellation or no-show policy. **Effective Monday, January 8th, CTI will begin charging a $25.00 fee to all patients that no-show or cancel less than 24-hours before their scheduled visit.** Any fee charged for a cancellation or no-show will need to be paid before your next visit. Failure to pay this fee will result in your visit being rescheduled.

It is our belief that this policy is essential to reduce lost treatment times and ensure our schedule is managed in such a way to minimize wait times for new patients. We hope for your understanding and cooperation with this matter.

Thank you very much,

John Jimenez, PT
Director of Clinical Services

Patient Initials/Signature: _____

Date: _____