

CUMBERLAND PHYSICAL THERAPY – Page 2

Name: _____

Date: _____

Diagnosis: _____ Date of Onset/Injury: _____

Are you currently taking any prescription or non-prescription medications? Yes No

List Medications: _____

Allergies: _____

Do you currently have, or have you ever had any of the following?

Heart Disease	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Seizures	Yes	No
Pace Maker	Yes	No	Asthma or Lung Disease	Yes	No
Infectious Disease	Yes	No	Are you pregnant?	Yes	No
Metal Pins or Implants	Yes	No	Do you smoke?	Yes	No
High Blood Pressure	Yes	No	Allergies	Yes	No
Osteopenia	Yes	No	Osteoporosis	Yes	No
CVA/Stroke	Yes	No			

If you checked yes to any of the above, please provide us with details:

Please list any major surgeries you have had and the approximate date:

Cumberland Orthopedic and Spine Physical Therapy

Consent to Treat

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending physical therapist.

The patient shall not be subjected to any procedure without his/her voluntary, competent and understanding consent or consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

After reading the above, I, _____, hereby consent to receive physical therapy treatment at Cumberland Orthopedic and Spine Physical Therapy, Inc., commencing on _____ and terminating when determined by myself, my physician, or my physical therapist.

I have read this information and understand its content.

Patient Signature: _____ Date: _____

Authorization to Release/Receive Information

I give my consent to Cumberland Orthopedic and Spine Physical Therapy, Inc., to disclose health information to my insurance carrier for the purpose of billing, to my physician or other healthcare professionals involved in my care, or receive health information from other healthcare professionals as it relates to my treatment, as permitted/required by law. I understand that confidentiality of my health information is protected under state and federal law, and that this release gives consent to Cumberland Orthopedic and Spine Physical Therapy, Inc., only, and not to any party to whom such information is released. (Please refer to the Privacy Notice for a more complete description of such uses and disclosures. You have the right to review the notice prior to signing this consent.)

Patient Signature: _____ Date: _____

Patient Payment Policy

The fee schedule of Cumberland Orthopedic and Spine Physical Therapy, Inc., is based on usual and customary fees for the type of services provided. Generally, your insurance policy will cover some portion, if not all, of the payment for services provided.

There is, however, no guarantee of payment. The balance amount, if any, that your insurance carrier does not cover will be your responsibility. You are also responsible for any deductible and co-pay. **PLEASE NOTE, IF YOU HAVE A COPAY WITH YOUR PRIMARY INSURANCE, AND YOU HAVE A SECONDARY INSURANCE, WE WILL AS A COURTESY TO YOU SUBMIT THIS TO YOUR SECONDARY INSURANCE A MAXIMUM OF TWO TIMES. IF NO PAYMENT IS RECEIVED OR YOUR SECONDARY INSURANCE DOES NOT RESPOND, YOU WILL BE BILLED AND EXPECTED TO PAY THE BALANCE, AT WHICH TIME YOU WILL BE GIVEN A "PAID" RECEIPT THAT YOU WILL THEN BE ABLE TO SUBMIT TO YOUR SECONDARY INSURANCE FOR REIMBURSEMENT.

We request that any insurance payments that are sent directly to you be presented promptly to Cumberland Orthopedic and Spine Physical Therapy, Inc., along with the explanation of benefits and/or any other information you received with the payment.

You are directly responsible for payment of medical supplies. Monthly statements will be sent to you if you have an outstanding patient balance. Payment for your portion of services, as outlined in the statement under the "Due From Patient" column is requested to be paid within fifteen (15) days of receipt of the statement.

I attest that my insurance coverage and personal financial responsibilities regarding physical therapy treatments have been fully explained to me.

Patient Signature: _____ Date: _____

Medicare Patients Only:

I request that payment of authorized Medicare benefits be made to me or on my behalf to the practitioner named above. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I have read this information and understand its content.

Patient Signature: _____ Date: _____

Rvs. 07/13/06

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all of your appointments. Write down the time of your visits so that you do not forget. It is also important that you arrive on time to your scheduled appointments. If you arrive more than 15 minutes after your scheduled appointment time, you may be asked to reschedule.

With the exception of serious emergencies it is expected that you keep all of your appointments. If you need to re-schedule an appointment we prefer a 24 hours notice. In such a case, please call our office to arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day. After 2 no show appointments, a 25.00 fee will be charged per visit.

In instances of repeated non-compliance with your scheduled visits, we must inform your physician of the fact that you have not followed his prescribed rehabilitation order and service may have to be discontinued at that time.

If you have any questions or concerns during the time that we will be providing care for you, please contact your Physical Therapist or ask to speak with our Patient Representative. We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understand this policy: _____ Date: _____

**NOTICE OF PRIVACY PRACTICES FOR
Cumberland Orthopedic & Spine Physical Therapy**

Acknowledgement of Receipt of Notice

Name: _____
(Please Print)

I acknowledge that I read the Notice of Privacy Practices (HIPAA) for Cumberland Orthopedic and Spine Physical Therapy.

(Signature of Patient/Parent/Legal Guardian)

Date of Receipt