Name: ________________________________

D.O.B: ________________________ Male/Female

S.S. #: ________________________________

E-mail: ________________________________

Address: ____

City: ______________________________ State: ___________ Zip: _______________

Phone numbers: (H)________________ (C) __________________ (W)__________________

I authorize CPAT to send appointment reminders via: (Please check one) Cell _____ Text_____ Home_____ Email _____

Area of injury: ___________________________________ Date of injury: _________________

Have you had physical therapy on this injury before ( ) No ( ) Yes If yes when? ______________________

Do you have a referral for Physical Therapy? Y/N Referring physician: _____________________________

Primary Care Physician: ______________________________ Phone: ______________________

How did you hear about Chesapeake Physical & Aquatic Therapy? ( ) My doctor specifically recommended CPAT

( ) I chose from my doctor's list ( ) Previous/Returning CPAT patient ( ) Family or Friend ( ) Internet Search

( ) Gym member ( ) Drove by ( ) Health Fair ( ) Radio ( ) Other: __________________________

Primary insurance: ___________________________ Policy holder: ______________________

Policy #: __________________ D.O.B: _____________ Relationship to patient: _______________

Group #: _______________ Phone: __________________ Policy holder SS#: _______________

Secondary insurance: _________________________ Policy holder: ______________________

Policy #: __________________ D.O.B: _____________ Relationship to patient: _______________

Group #: _______________ Phone: __________________ Policy holder SS#: _______________

Is your injury related to work? Y/N or an auto accident? Y/N If yes to either please continue

Employer: ____ Phone: ______________________

Address: __________________________ City: __________________ State: ______ Zip: __________

Insurance carrier name: ______________________________ Claim #: _______________________

Phone: _______________ Fax: _________________ Adjuster: ____________________________

Attorney: _________________________ Phone: _________________ Fax: __________________

Date of evaluation: __________ *Time:* _________ *Office:* ___________ *Therapist:* _______________

Columbia- Supreme
7080 Deepage Drive
Columbia, MD 21045
410-381-7000
Fax 410-381-3779

Columbia-Athletic Club
5435 Beaverkill Rd
Columbia, MD 21044
410-740-0883
Fax 410-381-3779

Catonsville
757 Frederick Rd. Ste103
Catonsville, MD 21228
410-719-8661
Fax 410-719-8996

Clarksville-River Hill
6151 Daylong Lane 5435
Clarksville, MD 21029
410-531-2525
Fax 410-531-2289

Elkridge
6785 Business Parkway
Elkridge, MD 21075
410-579-8999
Fax 410-782-8996

Owings Mills
10995 Owings Mills Blvd #210
Owings Mills, MD 21117
410-654-2300
Fax 443-378-8645

Welcome to Chesapeake Physical and Aquatic Therapy (CPAT)! We believe that communication with our patients regarding our financial policy assists us in providing you with the best possible service. Please take the time to read the following and sign at the bottom of the page. Thank You!

1. CPAT Staff will contact my insurance company and verify my physical therapy benefits. My insurance company will be billed as a courtesy, but this *does not* release me from my financial responsibility for my account.
2. Throughout my course of treatment, my insurance company will be billed daily. CPAT's policy is to collect co-payments and co-insurances at the time of service. Some co-insurance's are estimated based upon my insurance company's current fee schedule and therefore are subject to change.
3. I will periodically receive a statement regarding my account. I will review my statement to make sure my insurance company is processing my claim in a timely manner.
4. I am responsible for meeting my deductible, if applicable. I will be responsible for paying this amount before my insurance company will begin to pay.
5. Most insurance companies require either prescription or referral. I am responsible for obtaining updates prescriptions and referrals.
6. If my account becomes delinquent, I understand that I may be contacted by phone in order to bring my account up to date. I also understand that if my account becomes *90 days past due,* my account information may be sent to an attorney for collections. I agree to pay all costs and expenses of collections, including but not limited to; staff time, court costs, attorney fees of 1/3 of the balance due, collection agency fees, and any other related fees and expenses, plus late fees of 2% per month on the balance due.

SUMMARY OF BILLING PROCEDURES

☐ COMMERCIAL INSURANCE: I am responsible for my co-payment, co-insurance, and any outstanding deductible that may be due. CPAT will bill my insurance company and make every effort to collect on my claim. I remain responsible for any and all fees not paid by insurance, outside of contractual adjustments made by my insurance company.

☐ WORKERS COMPENSATION: I pay nothing out-of-pocket as long as my carrier pre-authorizes treatment.

☐ MEDICARE: Medicare will pay for 80% of allowable charges after the $147.00 deductible for Part B services has been met. In 2006, Medicare has established a cap on physical therapy, occupational therapy, and speech language pathology services. As a result, Medicare will only pay up to $1,870 for these services. All services rendered above this limit will be the responsibility of me, the patient. As a secondary insurance or if they do not pay, I will be responsible for the additional 20%, and/or deductible. Medicare also requires my physician to certify a plan of care (POC) every 90 days. After my initial visit every 30-90 days thereafter, CPAT will send a POC to my physician for his/her approval and signature. While CPAT will do their best to ensure they receive this from my primary care physician, I ultimately responsible to ensure proper authorization is obtained for my care. Failure of my physician to authorize care may result in Medicare denying payment thus shifting financial responsibility on to me.

☐ MVA: CPAT will bill my automotive insurance for services rendered. If benefits become exhausted, CPAT will bill my primary health insurance. At that point, guidelines for commercial insurance, as stated above, will be followed. If I do not have medical insurance, I will be responsible for payment.

☐ LITIGATION: If my treatment is related to injury or accident that involved legal proceedings, CPAT's policy is to *not wait* for settlement or payment. Therefore, I am responsible for payment at time of service.

☐ SELF-PAY: I agree to pay out of pocket for services rendered at CPAT's rates. I am responsible for payment at time of service.

Insurance Company: ________________________ Co-payment/Co-insurance: ________________________________

Deductible: ________ Amount Met to Date: ____________ Effective Date: ____________ Next Deductible Begins: ____________

Missed Appointment Policy: So that we best serve our patients, we require 24 hours notice for all appointment cancellations/no shows. Failure to provide such notice may result in a $30 NO SHOW fee which is due prior to your next appointment. Women's Health/ One hour session patients will be charged a $50 cancellation fee. Your insurance company *will not* pay for this fee, and you will be solely responsible for your payment. Patients who cancel appointments more than once without proper notice are subject to discharge from therapy. We appreciate your understanding and cooperation with this policy. We reserve the right to reschedule an appointment if the patient arrives 15 minutes late for a scheduled appointment, If a reschedule is not possible the patient may be held responsible for the set no show fee. I have been offered a copy of the above information and agree to the terms listed.

Signature: ____**Date:** ______________________________

Chesapeake Physical and Aquatic Therapy Health History
(Confidential)

Name: ______________________________**DOB:** _____________**Today's Date:** _________________

Emergency Contact: _________________**Relationship:** __________**Telephone:** _________________

Past and Current Medical History
Check () if you currently have or had in the past:

❑ Anemia	❑ Diabetes	❑ Insomnia
❑ Asthma	❑ Emphysema	❑ Irregular or rapid heart beat
❑ Bleeding Disorders	❑ Epilepsy/Seizures	❑ Osteoporosis
❑ Cancer	❑ Headaches	❑ Pacemaker
❑ Chest Pain	❑ Heart Disease	❑ Stroke
❑ Chemical Dependency	❑ High Blood Pressure	❑ Tuberculosis
❑ Depression	❑ HIV Positive	❑ Other ___________________

Past Surgeries:

____

____

Allergies and/or Medic Alert:

____

____

Current Medications: (Please list dose, frequency, and reason for each)

____

____

____

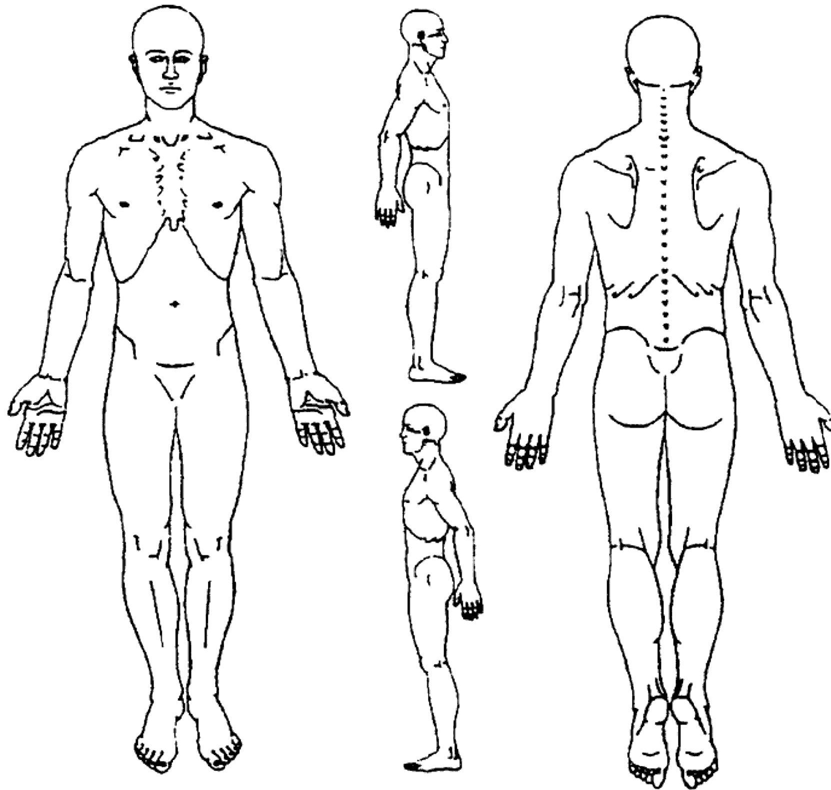
____

******Please fill out pain diagram on the following page******

Pain Diagram

Please mark the areas of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o o	^ ^ ^ ^ ^	x x x x x	☒☒☒☒
- - - - - -	o o o o o o	^ ^ ^ ^ ^	x x x x x	☒☒☒☒
- - - - - -	o o o o o o	^ ^ ^ ^ ^	x x x x x	☒☒☒☒
- - - - - -	o o o o o o	^ ^ ^ ^ ^	x x x x x	☒☒☒☒



Please use the space below to describe your condition further if needed:

____

____

____

____

____

Signature:________________________________ Date:________________________________

Consent to Treatment/Assignment of Benefits/Medical Release

I hereby consent to evaluation and treatment by my physical therapist at Chesapeake Physical and Aquatic Therapy (CPAT). I am responsible for notifying CPAT of any changes in my health or billing information. CPAT will make every effort to collect payments from my insurance company; however, I understand that regardless of my account status, I am ultimately responsible for all charges incurred for services rendered at CPAT to the extent the law allows.

Signature____Date______________________

I hereby give permission to Chesapeake Physical and Aquatic Therapy to release medical information to my insurance company, physician, attorney, assignees, and/or beneficiaries.

Signature____Date______________________

I authorize payment of my insurance benefits directly to Chesapeake Physical and Aquatic Therapy for all services I receive.

Signature____Date______________________

Thank You for Choosing Chesapeake Physical and Aquatic Therapy as your Physical Therapy Provider!