PATIENT BILLING INFORMATION
NEW PATIENT (Page 1 of 2)

Name:____
First Name | Last Name | Middle Initial

SSN: : _______-______-________ Sex: ______M ________F Date of Birth: _____/______/______

Marital Status: ☐ Single ☐ Married ☐ Other

☐ Employed ☐ Full-time student ☐ Part-time student

Address: ____
No. Street

____
City State Zip

E-mail Address: ______________________________________Primary Phone number: (_____) ______ - _______

Work Phone: (_____) ________ - ____________ Cell Phone: (_____) ________-____________

Would you like a reminder call about your next appointment by:

______ phone (please circle: Home / Cell)
______ text message
______ email
______ please do not confirm

Do we have your permission to leave a message on your answering machine or voice mail? ____yes ____no

Do you wish to give permission for your Therapist to discuss your condition with another person? ___yes ___ no

If yes, who ____

Have you received any home health care services in the past 3 months? ____yes _____no

If yes, what was your discharge date: ______/______/_______

What agency?____

Have you received out-patient physical therapy in any clinic or hospital in this calendar year? Yes ___ No ___

Is your condition related to:

Work related injury?	____ no	____ yes
Auto accident?	____ no	____ yes
Other Accident?	____ no	____ yes

How did you hear about us? ____ Doctor ___ Insurance Co. ____ Phone book ____ web-site ____ friend/family

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What is your relationship to the insured: ___ Self ___ Spouse ___ Child ___ Other

If you are **not** the primary policy holder (ie: you have insurance through your spouse or parent) please answer the following:

Name of insured: ______________________________

Insured date of birth ____/____/____ Insured place of employment: ____________________

Insured Address (if different than patient): ______________________________

____

Please list at least one person we can contact in case of emergency:

1. Name: ____________________ Phone: (___) ____ - ______

   Address: ______________________________

   Relation: ______________________________

2. Name: ____________________ Phone: (___) ____ - ______

   Address: ______________________________

   Relation: ______________________________

Please indicate your next physician's visit so that we are able to send a progress note: _____/____/_____

PATIENT NAME: ________________________________ DATE OF BIRTH: ___/___/___

MEDICAL HISTORY

Allergies	O Yes O No	Depression	O Yes O No	Multiple Sclerosis	O Yes O No
Anemia	O Yes O No	Diabetes	O Yes O No	Osteoporosis	O Yes O No
Anxiety	O Yes O No	Dizzy Spells	O Yes O No	Parkinsons	O Yes O No
Arthritis	O Yes O No	Emphysema/Bronchitis	O Yes O No	Rheumatoid Arthritis	O Yes O No
Asthma	O Yes O No	Fractures	O Yes O No	Seizures	O Yes O No
Cancer	O Yes O No	Gallbladder Problems	O Yes O No	Speech Problems	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Strokes	O Yes O No
Cardiac Pacemaker	O Yes O No	High Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Chemical Dependency	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Circulation Problems	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Currently Pregnant	O Yes O No	Metal Implants	O Yes O No		

Describe any other conditions or precautions:

Mark on the diagram below the location of the pain or symptoms you have right now:

Falls History

Injury as a result of a fall in the past year? O Yes O No Date of Fall: ________________

Two or more falls in the last year? O Yes O No Dates of Falls: ________ ________

Surgical History

Body Region: ________ **Surgery Type:** ________ **Date of Surgery:** ________
Body Region: ________ **Surgery Type:** ________ **Date of Surgery:** ________
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Current Medications

Drug: ________ Dosage: ______ Frequency: ______ Route: ______ Reason Taking: ________
Drug: ________ Dosage: ______ Frequency: ______ Route: ______ Reason Taking: ________
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Creative Therapy
Resource, Ltd.

The advanced training you need.
The personal attention you deserve.

Authorization Form

- I authorize Creative Therapy Resource, Ltd. to release any medical or other information necessary to process this claim to my insurance company
- I authorize Creative Therapy Resource, Ltd. to bill my insurance company.
- I authorize my physician to release any medical or other information necessary for my therapist to fully understand my condition and plan an appropriate treatment plan. I also authorize Creative Therapy Resource, Ltd. to release information to my physician regarding my treatment plan and progress during physical therapy.
- I acknowledge that I am wholly responsible for full payment to Creative Therapy Resource, Ltd. for all physical therapy services rendered, including all applicable co-payments, and any amounts not paid by insurance. In the event that Creative Therapy Resource, Ltd. has entered into an agreement with my insurance company to reduce their rates, Creative Therapy Resource, Ltd. will not bill me any PPO agreed upon reductions. In the event of default, any legal and collection fees necessary in collecting this account are my responsibilities.
- I acknowledge that I have received and understand Creative Therapy Resource, Ltd.'s cancellation policy and payment policies
- I acknowledge that I have been shown a copy of Creative Therapy Resource's privacy policies and have indicated my desire for a copy of the policy below:
  - ☐ I do not want to have a copy of the privacy policy _____(Initial)
  - ☐ I want a copy of the privacy policy _____(Initial)

Signed: ______________________________ Date: ______________________

Printed name: ___________________________Relation to patient: ______________