The Cantrell Center for Physical Therapy & Sports Medicine, P.C.
Phone: 478-953-3535
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www.cantrellcenter.com

Cantrell Center
WARNER ROBINS, GA
Cantrell Center
PHYSICAL THERAPY • WELLNESS

Patient Information **Date:**

First Name: MI Last Name: Age: Date of Birth :

Address (Street Name & Number): City: State: Zip:

Mailing Address *(If different)*: City: State: Zip:

Home Phone: Cell Phone: Work Phone: Ext.

Sex: SSN#: Martial Status

☐ Married ☐ Single ☐ Divorce ☐ Widowed

May we text and/or e-mail you an appointment reminder?
(Please check one, both, or neither)

☐ Text ☐ E-Mail E-mail Address:

Cell Phone Carrier: Carrier:

☐ Verizon ☐ Sprint ☐ AT&T ☐ T-Mobile ☐ Other

Employment Status

☐ Employed Full-time ☐ Employed Part-Time ☐ Unemployed ☐ Retired

Occupation: Your Employer:

Spouse/ Parent/ Guardian Information

Spouse/Parent/Guardian Name: MI Last Name: SSN#:

Relationship: Cell Phone: Work Phone:

Date of Birth : Employer Name:

Spouse/Parent/Guardian Name | MI | Last Name | SSN#:

Relationship: | Cell Phone: | Work Phone:

Date of Birth : | Employer Name:

Emergency Contact: | Phone Number | Relationship:

Patient Medical History: **(PLEASE CHECK ALL THAT APPLY)**

- ☐ SMOKE
- ☐ DRINK
- ☐ DRUGS
- ☐ EXPOSED TO HIV
- ☐ PREGNANT? IF PREGNANT, HOW LONG?
- ☐ Arthiritis- Osteo
- ☐ Arthiritis- Rheumatoid
- ☐ Dentures
- ☐ Epilepsy
- ☐ Allergies
- ☐ Do you carry Epipen?
- ☐ Swelling
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Metal Implant
- ☐ Heart Problems
- ☐ Incontinence
- ☐ Osteoperosis
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Fractures
- ☐ Heart Pacemaker
- ☐ Migraines
- ☐ Liver Disease
- ☐ Shortness of Breath
- ☐ Tumor
- ☐ Excessive Bleeding
- ☐ Asthma
- ☐ Pelvic Pain
- ☐ Other:

YEAR	SURGERY

Injury Date or Date Pain Began:

Describe symptoms/pain/injury you are being treated for today:

If injury, how did injury occur?

- ☐ Home
- ☐ Work
- ☐ Auto Accident

If Auto accident, in which state?

- ☐ Other:

How Did You Hear About Our Office?

- ☐ You are a Returning Patient — If so, date last seen:
- ☐ A Former Patent — If so, which patient?:
- ☐ Your Employer — If so, who is your employer?
- ☐ Insurance Benefit Plan — If so, plan name:
- ☐ Wellness Member — If so, who?:
- ☐ Other: — Please define other:

Friends of the Cantrell Center are very special to us. Did anyone ***other than*** your physician recommend you to the Cantrell Center? We would like to thank them.

First Name:

Last Name:

Address (Street Name & Number):

City:

State:

Zip:

Referring Physician:

Date of Next Doctor's Appointment:

If you were referred to us by a doctor other than your primary care physician, who is your family physician so that we may forward your progress notes to him or her?

Primary Care Physician:

Telephone Number:

Have you been treated by any of the following since January 1st of this year? **(PLEASE CHECK ALL THAT APPLY)**

☐ Physical Therapist ☐ Chiropractor ☐ Home Health Care Agency ☐ None

If so, have you been discharged from their facility?:

If so, date last seen/treated:

Physical Therapy Office:

Phone Number:

Chiropractor's Office:

Phone Number:

Home Health Care Agency:

Phone Number:

Date you were discharged from Home Health Care:

Have you X-rays/MRI? When? Where?

TO BE COMPLETED AT CHECK-IN

My insurance benefits have been verified and explained to me prior to my first visit. NOTE: This is an ***estimate*** and **not a guarantee of benefits** as described by your insurance carrier(s): $_____/_____ Deductible(s), Co-insurance _____/_____ % and/or $_____/_____ co-pay. **I understand and agree my co-pay is required each visit and/or co-insurance payment is required a minimum of once per week.**

Initial in Agreement _____

I have received and understand the Cantrell Center's Notice of Information Practices. I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Cantrell Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initial in Agreement _____

ASSIGNMENT OF BENEFITS STATEMENT & CONSENT FOR TREATMENT

Patient Name:

CONSENT FOR TREATMENT

I, _____ , voluntarily give my consent to the Cantrell Center for Physical Therapy and Sports Medicine, P.C. to evaluate and treat my condition, including the consent to receive telehealth services.

Authorization for Release of Medicial Information and Assignment of Benefits

For consideration of services rendered by The Cantrell Center for Physical Therapy & Sports Medicine, P.C. I hereby guarantee payment of all charges incurred by above named patient. I hereby authorize the payment of benefits of my insurance policy to be paid directly to The Cantrell Center for Physical Therapy & Sports Medicine, P.C., for services rendered. I further authorize this office to release/receive any information acquired in the course of my examination and treatment to my insurance company, other physicians, hospital, clinics or The Cantrell Center for Physical Therapy & Sports Medicine, P.C. I authorize The Cantrell Center for Sports Medicine, P.C. to request credit information from any credit bureau.

I authorize The Cantrell Center to release information regarding my care/treatment to the following family members (spouse, children, siblings):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

It is the patient's responsibility to keep personal items with them at all times.

I also authorize The Cantrell Center to photograph me for the purpose of identity in my medical records not to be shared with any outside sources. I understand and authorize that if photos are taken of my injury during the course of treatment, that these photos can be shared with insurance carriers or attorneys if requested to insure payment and/or for educational purposes.

As a service to you, our office will bill your primary and 2nd insurance companies for charges incurred. All deductibles, co-pays, and coinsurance balances will be due on the date services are rendered.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT IN THE EVENT OF DEFAULT OF PAYMENT OF MY ACCOUNT, A $50.00 COLLECTION FEE WILL BE ADDED TO MY OUTSTANDING BALANCE. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL ATTORNEY AND LEGAL FEES INCURRED TO COLLECT THIS BILL.

Patient Name:

Responsible Party (if other than patient)

Initial in Agreement _____ Date: _____

THE CANTRELL CENTER
FINANCIAL POLICY

Thank you for choosing us as your physical therapy provider. We are committed to providing the best care possible for all ages and all needs in a comfortable and friendly environment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions regarding fees, FINANCIAL POLICY, or your responsibility.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD
All returned checks will result in a $25.00 service charge

I will be paying by: ☐ CASH ☐ CHECK ☐ VISA/ MASTERCARD

CO-PAYMENT is due at time of services (including deductibles, and non-covered services)

REGARDING INSURANCE

If you have insurance, our staff will call and verify benefits and eligibility prior to your first visit, please note that benefits given are a ***quote*** and **NOT a guarantee of payment or coverage**. Coverage and payment is determined once your insurance receives and processes your claim. As a courtesy, we will file your primary and secondary insurance. We will help you to receive maximum benefits. If you have not met your annual deductible, you will be required to pay a $160.00 deposit. You will be required to pay all co-payments, estimated coinsurance, and deductibles at the time of service or on a weekly basis. Your estimated insurance payment is based on benefits given by your insurance company. We are contracted with many insurance companies and accept the negotiated allowable fees as agreed by contract. If we are not contracted with your insurance, we are not responsible for amounts of any insurance company's arbitrary determination of usual and customary rates.

Once insurance has completed payment on your account, the balance is due in full. **With prior credit approval,** we will accept a minimum monthly payment of 20% of the total balance ***or*** $60.00, whichever is greater. Any difference from the estimated amount and the amount actually paid by your insurance company is YOUR responsibility. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

NON-INSURANCE PATIENTS

All patients without insurance will be required to pay in full at the time of service. Credit cards, cash, and checks will be accepted.

LIABILITY ACTION-LITIGATIONS

It is your responsibility to make our office staff aware if court action on your case is a possibility. With prior approval, we will accept a letter of protection or attorney lien on third party claims. You and your attorney must sign a lien. Payment of the bill is the responsibility of the individual who receives treatment, not the individual who is being sued. A monthly payment plan will be established for you at the beginning of treatment. If claim has not settled within 90 days from discharge date, then payment must be made in full. We accept Cash, check or Visa/MasterCard.

MISSED APPOINTMENTS

It is your responsibility to notify us 24 hours prior to cancellations or rescheduling. A missed appointment or cancellation without such notice will be subject to a nonrefundable charge of $25.00 per missed appointment, which will be billed directly to the patient. This charge is not billable to commercial insurances or Workers' Compensation. Please help us serve you better by keeping scheduled appointments.

Patient Name:	Initial in Agreement	Date: