Carefree
PHYSICAL THERAPY

7208 E. Cave Creek Rd., Suite H
P.O. Box 5924
Carefree, AZ 85377
480-488-9095

Welcome to Carefree Physical Therapy. Please complete the following information as accurately as possible. **All information is required to process any medical claims to your insurance.**

PERSONAL INFORMATION

Date 1/24/24

First name: _____ MI: ____ Last name: _____

Mailing address (please include city and zip) Other address (please include city and zip)

_____ _____

_____ _____

Would you like a reminder text prior to your appointments? Yes ☐ No ☐

Cell phone: (____)_____

Home phone: (____)_____ Email address: _____

Date of birth: ____/____/____ Gender: ☐ Female ☐ Male

Social security number: ____/____/____ Marital status: ☐ Single ☐ Married ☐ Widowed

Who should we contact in the event of an emergency? _____

Phone: _____ Relationship to you: _____

MEDICAL INFORMATION

Reason for therapy: _____ Prescribing physician: _____

Date last seen by this physician: _____ Next appointment: ____/____/____

Date of surgery, if applicable: ____/____/____ Date of injury, if applicable: ____/____/____

Who is your primary care physician for all other medical care? _____

Are you receiving any type of medical service at home (any nurse, therapy, etc)?

☐ Yes ☐ No If so, what was your discharge date? ____/____/____

Is your injury result of:

☐ Work Comp ☐ Auto ☐ Personal Injury

If so, DOI: ____/____/____ Claim number _____

Please review our office policies and sign the back of this page.

Consent to Treatment
I authorize and consent to an initial evaluation and medically necessary treatment by Carefree Physical Therapy. Specific treatment procedures and activities will be explained in the course of treatment. Treatment may require exercises and activities with an increasing degree of difficulty and may increase your level of pain. I agree to participate with the physical therapy evaluation and plan of care and to communicate changes and concerns with my physical therapist.

Notice of Privacy Practices
I acknowledge that I have been presented with a copy of the Notice of Privacy Practices of Carefree Physical Therapy. I authorize the use and disclosure of my personal health information for purposes included in the Notice. I understand that I may revoke this consent by notifying Carefree Physical Therapy in writing at any time.

Financial Agreement
Carefree Physical Therapy will contact your insurance provider and verify your benefits as accurately as possible. We strongly recommend you also contact your insurance carrier and verify your policy and benefits. Please keep us informed of any changes to your personal information and/or health insurance information so that your claims will process promptly and fully. It can take 4-8 weeks for the insurance company to process your claims. I authorize Carefree Physical Therapy to bill my health insurance on my behalf and I thereby assign all medical benefits to Carefree Physical Therapy.

I understand and acknowledge that I am financially responsible for payment of services provided to me and that I will pay my portion due at the time of service. This includes, but is not limited to co-payments, coinsurance, and deductibles that are not covered by my health insurance. I understand that verification of my insurance benefits is not a guarantee of payments, and that the insurance company determines benefit payments.

I understand that a $35 cancellation/no show fee will be charged if I do not give the FRONT DESK 24 hours notice of each cancellation. This fee is not billed to insurance, and I agree to pay it.

I understand that I will receive a statement for all unpaid services if I do not pay at the time of service. If I fail to pay my account balance in full after three final statements, I understand that my account may be referred to a collection agency.

DESIGNATED INDIVIDUALS AUTHORIZATION
I authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name_____ Relationship _____

Name_____ Relationship_____

I have read and understand the above information.

Patient Name _____

Patient Signature _____ **Date** _____

Legal Guardian Signature _____ **Date**_____