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 _____

First name: _____ MI: _____ Last name: _____

Mailing address (please include city and zip)

_____

_____

Other address (please include city and zip)

_____

_____

Home phone: (____)_____ Email address: _____

Cell phone: (____)_____ Text appointment reminders: Yes ☐ No ☐

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: _____ Referring 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? _____

Occupation _____

Are you receiving any type of medical service at home (any nurse, therapy, etc) ☐ Yes ☐ No

When 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.

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CONSENT TO TREAT

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 charges 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 AND ASSIGNMENT OF BENEFITS

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 no give the FRONT DESK 24 hours' notice of each cancellation. This fee is not billed to insurance and I agree to pay it.

Carefree Physical Therapy does not take responsibility for misquoted benefits or claims denied for any reason.
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** _____

Primary Insurance _____ **ID** _____ **Group** _____

Supplemental Insurance _____**ID**_____**Group**_____

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

Patient/Legal Guardian name _____ **Date**_____

Patient / Legal Guardian Signature _____