CENTRAL PHYSICAL THERAPY
13111 HOOPER ROAD
CITY OF CENTRAL, LA 70818
225-261-7094

PAYMENTS AND INSURANCE

We at Central Physical Therapy would like to thank you for choosing our facility for your physical therapy needs. Central Physical Therapy will accept assignment of insurance benefits, but your insurance policy is a contract between you and your insurance company and as such, we are not party to that contract. As a courtesy, we will bill your insurance company with the appropriate billing information provided by you. All insurance policies are different. Not all medical services performed may be covered under your plan and not considered 'reasonable' by your insurance policy. Any remaining balance on your bill will be your responsibility. Statements will be sent out monthly and timely payment is appreciated. Many insurance companies require a co-payment at the time of visit. If your insurance does have a co-payment plan, we will need your payment at the time services are rendered. As always, we will do anything to assist you in this process. Please feel free to contact us if we can be of any assistance.

Release of Benefits Authorization

I authorize the release of any medical information to any and all parties involved in reimbursement to process my insurance claim(s). I hereby assign all payments to Central Physical Therapy rendered to myself or my dependents which I have not paid. I understand that I am responsible for my account and not the insurance company. A Photostat of the authorization shall be as the original.

Name_____**DOB**_____

_____ ____/____/_____
Signed (Patient or Responsible Party) **Date**

Patient Consent

I hereby indicate my wish to be a participant in the rehabilitation program offered by Central Physical Therapy. I understand that the purpose of this program is to enhance my recovery from an injury or illness. I further understand that there exists the possibility that certain changes may occur during my treatment. I have been informed and have participated in the Plan of Care. I have also been informed of the procedures and methods of treatment that will be administered to me, and fully voluntary, no coercion of any sort has been used to obtain my participation, and I may withdraw from treatment at any time. I understand that the facility Administrator maintains an open-door policy and encourages patients to participate for any reason.

_____ ____/____/_____
Signed (Patient or Responsible Party) **Date**

BEGINNING AUGUST 1, 2015

If a scheduled patient does not show or call to reschedule, then the patient will be charge a $25 fee. The $25 fee will be collected on the next attended appointment in addition to any other collectible payment. We do have an appointment reminder system by text or e-mail for your convenience.

_____ ____/____/_____
Signed (Patient or Responsible Party) **Date**

PATIENT REGISTRATION

Last Name First Middle Initial (Name you prefer to go by) Age

Address City State Zip

DOB: _____ Sex _____ SSN _____ Email _____

Employer: _____ Home Phone _____ Cell Phone _____

Emergency Contact: _____ Phone # _____ Relationship: _____

Marital Status: _____ Spouse Name_____ Spouse Phone # _____

***Do we have permission to discuss your condition with your emergency contact? Y or N. (Please circle one)**
***Do we have permission to leave a message on your voicemail? Y or N (Please circle one)**
***Would you like to receive appointment reminders from us through Text, Email, or Both? (please circle one)**

Highest level of Education: _____

If patient is a minor:

Father's Name _____ Phone Number _____

Mother's Name_____ Phone Number _____

Primary Insurance: _____ Policy # _____

Policy Holder of Primary Insurance: _____ DOB: _____

Secondary Insurance: _____ Policy # _____

Policy Holder of Secondary Insurance: _____ DOB: _____

Are you receiving Physical Therapy as a result of:

Motor Vehicle Accident, Work Related Injury, Surgery, or Sports/School Injury? _____ Date _____

Have you retained or plan to retain an attorney related to your accident/injuries? Y or N. If yes, please provide name,

phone number and address of your attorney_____

Name of other party involved in accident and Name of his/her adjuster: _____

If you have been contacted by an insurance adjuster relating to your accident, please provide the following information.

Name of Insurance Company _____ Claim Number _____

Name of Adjuster _____ Adjuster Phone Number _____

Have you ever had outpatient Physical Therapy in a hospital? Y or N. Have you been under the care of a Home Health Agency for Physical Therapy/Speech Therapy? Y or N. If Yes, Have you been discharged? Y or N.
Please list name of Home Health Agency _____

How did you hear about us? Physician, Friend, Advertisement, Our website, Facebook

Signature _____ Date _____

Please provide the following information related to your Medical History

Name _____ DOB: _____

Are you under the care of a Physicain? Y or N. If yes, Please explain: _____

_____

When was your last physical exam? _____

Do you have any disease or problem not listed below that you feel we should know about? _____

Existing or Relevant Previous Conditions:

Allergies	YES NO	Diabetes	YES NO	Metal Implants	YES NO
Anemia	YES NO	Dizzy Spells	YES NO	MRSA	YES NO
Anxiety	YES NO	Emphysema/Bronchitis	YES NO	Multiple Sclerosis	YES NO
Arthritis	YES NO	Fibromyalgia	YES NO	Muscular Disease	YES NO
Asthma	YES NO	Fractures	YES NO	Osteoporosis	YES NO
Autoimmune Disorder	YES NO	Gallbladder Problems	YES NO	Parkinson's	YES NO
Cancer	YES NO	Headaches	YES NO	Rheumatoid Arthritis	YES NO
Cardiac Conditions	YES NO	Hearing Impairment	YES NO	Seizures	YES NO
Cardiac Pacemaker	YES NO	Hepatitis	YES NO	Smoking	YES NO
Chemical Dependency	YES NO	High Cholesterol	YES NO	Speech Problems	YES NO
Circulation Problems	YES NO	High/Low Blood Pressure	YES NO	Strokes	YES NO
Covid-19	YES NO	HIV/AIDS	YES NO	Thyroid Disease	YES NO
Currently Pregnant	YES NO	Incontinence	YES NO	Tuberculosis	YES NO
Depression	YES NO	Kidney Problems	YES NO	Vision Problems	YES NO

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doings things? YES NO

Describe any other conditions:

Fall History:

Injury as a result of a fall in the past year? YES or NO

Two or more falls in the last year? YES or NO

Do you use a walker or cane? YES or NO

Please describe how you have fallen.

Surgical History: (Please list and date your most recent surgeries)

Signature _____ Date_____

CENTRAL PHYSICAL THERAPY

Medication List Including Supplements and OTC

Name_____DOB_____

Allergies/Drug Allergies_____

Drug (Do Not Abbreviate)	Dosage	Reason and Route(orally, topical, injection)	How Often Per Day
			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4
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			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4
			☐1 ☐2 ☐3 ☐4

_____ √ if not on any medications _____ Please Initial to verify

Physical Therapist Signature _____Date_____

PAIN CHART

Name:_____ Referring Doctor: _____

What is your current weight _____lbs Height _____ft. _____in.

Please explain why you are here. (How did it happen and Date): _____

_____

_____

Show Us Where It Hurts

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using the scale from 1 (discomfort) to 10 (extreme pain):

DESCRIPTION:	Numbness	Pins & Needles	Burning	Aching	Stabbing
SYMBOL:	N	P	B	A	S

INTENSITY: 0 1 2 3 4 5 6 7 8 9 10

Circle any area of pain not represented by a symbol.