CHESTERTOWN PHYSICAL THERAPY SERVICES, INC.

818 HIGH STREET STE. #1 CHESTERTOWN, MD 21620
PH: 410-778-6565 FAX: 410-778-6536 WWW.CTOWNPT.COM

Please provide the necessary information below as accurately as possible so that we may correctly process insurance billing. Please ask our office staff if there are any questions or concerns.
Thank you for choosing Chestertown Physical Therapy

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ____/____/____ Social Security # _____ Sex: Male / Female

Street _____ Apt.# ____ City _____ State ____ Zip _____

Phone Contact: Home (____) _____ Work (____) _____ Cell (____) _____

Email address: _____

Preferred contact name & phone for appointment reminders/scheduling: _____ (____) _____

Marital status: Single Married Widowed Divorced Spouse's Name _____ Date of Birth ____/____/____

Emergency contact name & phone: _____ (____) _____

Are you currently working? Yes / No Employer Name: _____ Have you had prior physical therapy? Yes / No

If you have Medicare, are you currently receiving Home Healthcare Services for any reason? Yes / No

Referring Physician _____ Office Phone (____) _____

Primary Care Physician _____ Office Phone (____) _____

Insurance Information

Is this injury a result of an Auto accident? Yes / No **Workers Compensation?** Yes / No Date of Injury ____/____/____

Type of Injury: _____ Insurance Carrier: _____

Claim# _____ Adjuster Name/Phone: _____ (____) _____

If you do not have insurance please see the front desk to make payment arrangements.

Provide staff with your current/valid insurance cards on your first visit.

SCHEDULING: We will make every effort to schedule an appointment at the most convenient day and time for you and if you need to change an appointment we will make every effort to accommodate your busy schedule. We suggest that you schedule your appointments two or three weeks in advance whenever possible.

*****Please remember it is important that you call at least 24 hours in advance to cancel an appointment so that we may use that time for another patient. If you don't cancel your appointment prior to 24 hours of the scheduled time and/or 'no-show' for the scheduled appointment you will be charged $25.00. After the third cancellation, or 'no-show' you will be referred back to your physician to renew your physical therapy prescription.**

Initial _____

INSURANCE: We are happy to bill your insurance company as a courtesy and convenience if we are provided with appropriate billing information. If we do not receive proper information, payment may be required at the time services are rendered. **Initial:**_____

Your Insurance Benefit Notification

Co-pay amount _____ per visit Deductible _____ Co-insurance _____per visit

Visits authorized _____ per calendar year / contract year

I am aware of the nature and extent of my insurance coverage and understand that co-pays are expected when I sign in for each appointment. **Initial** _____

MEDICARE: Beginning January 1, 2010 adhering to Medicare guidelines for physical, speech and occupational therapy, there will be financial limitations for therapy services. The dollar amount for the 2022 limitation from January 1, 2022 thru December 31, 2022 will be $3,000. You will be responsible for any therapy services provided beyond the Medicare limitation. **Initial**_____

NO INSURANCE: We are happy to provide services to patients not participating in a health insurance program, but we must insist payment be made at the time services are rendered. We do offer a payment program. Please ask our front office staff for more information. **Initial**_____

I understand if I have an unpaid balance to Chestertown Physical Therapy and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts. **Initial**_____

In order for Chestertown Physical Therapy or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Chestertown Physical Therapy and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Initial _____

I certify the above information is correct. Chestertown Physical Therapy employees have my permission to contact me by phone, voicemail, answering machine, mail, text or email regarding appointments, collections or marketing. I consent to the evaluation and plan of treatment made by my therapist. I authorize the release of all medical information necessary to process my medical claims. I also authorize my insurance company to make payment directly to Chestertown Physical Therapy Services Inc. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered and any collection fees incurred for the above named patient.

Signature _____ **Date** ____/____/_____

(parent must sign if patient is under the age of 18)

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Julia H. Bainbridge, PT
Joanna M. Blackburn, MPT
Bruce M. Blackburn, MPT, CWS
Certified Wound Specialist

Irvin Miller, P.T.
Electromyography

CLINICAL INTAKE FORM

Patient Name: _____
Date: _____

Past Medical History: (Please check off the following)

- High or Low Blood Pressure _____
- Diabetes and/or Circulation Problems _____
- Stroke/CVA/TIA _____
- Heart Problems _____
- Asthma/Breathing Problems _____
- Cancer _____
- Seizures/Fainting _____
- Other _____

Allergies to Medications: (Please list)

_____
_____

Current Medications Being Taken (prescription & over the counter):

Medication Name	Reason for Taking	Dose/frequency (if known)

Recent Hospitilization/Surgery/Illnesses:

Date	Reason

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INFORMED CONSENT for Speech Language Pathology

I, _____, hereby agree to routine speech therapy evaluation and treatment by a licensed speech therapist or under his/her supervision as ordered by my physician. I understand and am informed that, as in the practice of medicine, speech language and feeding therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about mine or my child's condition, prior to treatment. I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist. I consent and authorize Chestertown Physical Therapy, LLC., to administer treatment under the direction and supervision of a certified speech-language pathologist.

My consent to any treatment set forth is voluntary and I may withdraw any such consent at any time and to any aspect of the prescribed treatment.

Your Responsibility as a Patient:
To gain expected benefits you must give priority to regular attendance and adherence to prescribed amounts of intensity, duration, frequency, progression, and type of activity. To achieve the best possible results, report any unusual symptoms which you experience before, during, or after a speech therapy treatment session.

I have read or have had read to me the above consent. By signing below, I agree to receive routine speech therapy treatment as explained to me by the treating speech therapist. My signature also attests to the fact that I have been given Patient's Rights and Responsibilities and the Notice of Privacy Practices. I intend this consent to cover the entire course of treatment for my present condition and for any future condition for which I shall seek treatment from Chestertown Physical Therapy, Inc.

X *Patient's Name(please print)*_____
X *Patient's Signature Date*_____

Use and Disclosure of Protected Health Information

I understand that Chestertown Physical Therapy Services, Inc. (Practice) may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that a copy of the Practice's Notice of Privacy Practices was made available to me, which provides information about how the Practice, and individuals involved in my care in the Practice may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at 410-778-6565.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment, or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance to my prior consent.

Patient or Legal Representative	Date	Relationship to Patient

Witness	Date

NOTICE:

COPAYS/COINSURANCES

ARE DUE EACH VISIT

We accept cash, check, Visa, MC or Discover.

- ✓ Please be aware that we have a 24 hour cancel/no show policy. If you cancel your appointment within 24 hours of the scheduled time and/or "no show" for the scheduled appointment you will be charged $25.00.
- ✓ Our office will provide a printed schedule and phone call to remind you of your appointment.
- ✓ For those patients coming to the pool please bring your towel from home. We don't provide towels but they can be purchased at the front desk.
- ✓ We have payment plan options and it is encouraged that you talk with our billing office within the FIRST week of therapy to discuss a payment plan.
- ✓ Legally the "COPAY" is to be collected EACH visit.
- ✓ The "Co-Insurance" amount can fluctuate depending on the charges per visit and therefore it is requested that a fee of $20 be collected each visit to help offset the ending month balance.
- ✓ Any balance shall be paid by the last business day of the month.

CHESTERTOWN PHYSICAL THERAPY

Health Declaration Form

In order to keep you and all members as safe as possible, we ask that you read and sign the following declaration:

I, _____, will not visit the therapy office if I can answer YES to any of the statements below.

- Tested positive for Coronavirus in the past month and haven't had a negative test or been cleared by MD to be in public.
- Been ID as a carrier of Covid-19 and not cleared by MD to be in public.
- Been in a location that has been ID as area with positive COVID-19 where you were NOT protected by appropriate PPE.

I will not visit Therapy if I have any of the symptoms recognized by the CDC:

- Fever/chills (temperature over 100.4)
- Cough
- Shortness of breath or difficulty breathing (that is not your usual)
- Fatigue, muscle aches and headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose (not allergy related)
- Nausea or vomiting
- Diarrhea
- Persistent pain of pressure in the chest
- New onset of confusion

Any new onset of symptoms will need to be checked and then cleared by your physician prior to coming into the therapy environment.

In signing below, I agree to the terms of this Health Declaration and will continue to keep my health and the health of fellow patients and professionals a priority.

X_____ Date:_____