CAPTA THERAPY REGISTRATION

capta physical therapy

Name _____ **Patient Account #** _____

_____

Last Name **First Name** **Middle Initial**

Mailing Address _____

City _____ State ____ Zip _____

Home Phone _____

Work/Cell Phone _____

E-mail (optional) _____

Billing Address _____
(If different from mailing address)

City _____ **State** _____ **Zip** _____

REQUIRED FOR BILLING:

Birth date_____ Age____ Male____ Female _____

Married____Single_____Divorced_____Widowed _____

Social Security Number: Patient _____

Social Security Number: Insured _____

Emergency Contact _____

Emergency Phone / Relationship _____

Referring Dr. _____

MANDATORY IF YOUR CONDITON IS RELATED TO WORKER'S COMP & AUTO CLAIMS

Employer _____

Occupation _____

Address _____

City _____ State _____ Zip _____

Is your condition related to:

Work _____ Claim # _____

Auto _____ Claim # _____

Auto Insurance _____

Claim Representative _____

Claim Representative Phone _____

Who is your primary care physician? _____

Does your insurance require certification/authorization? _____

Have you been seen at a Capitol Physical Therapy clinic before? Y N **Please circle below:**

Delta Clinic
701 Snow Road

DeWitt Clinic
12800 Escanaba Dr.

East Lansing Clinic
830 W. Lake Lansing Road

Mid-Michigan Clinic
1540 Lake Lansing Rd

Charlotte Clinic
616 Meijer Road

For Office Use

Onset Date _____ Body Region _____

Referral Date _____ Diagnosis _____

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Name _____ **Patient Account #** _____

How did your problem begin / injury occur? _____

_____

_____

Complaints regarding this injury / problem: _____

_____

_____

Date of Injury: _____ **Date of Surgery:** _____

Related treatments and results: _____

_____

_____

Medications (all): _____

_____

_____

Allergies: _____

Related Surgery _____

Related Tests: X-Rays: _____ CT Scan: _____ MRI: _____ EMG: _____

Other _____

Other existing medical conditions: Pregnancy: _____ Diabetes: _____ High Blood Pressure: _____

Neurological Condition: _____ Metal Implants: _____ Epilepsy: _____ Respiratory Disorder: _____

Heart Problems (explain): _____ Cancer: _____

Other _____

Employment: Full Time: _____ Part Time: _____ Student: _____ Retired: _____ N/A: _____

Work Status: Off Work: _____ Working with restrictions: _____ Working without restrictions: _____

Occupation & Work Duties: _____

_____

_____

_____

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Mark ALL activities that you are having difficulty performing:

_____ Sitting	_____ Standing	_____ Walking	_____ Stairs / Curbs	_____ Lifting
_____ Reaching	_____ Writing	_____ Self Care	_____ Dressing	_____ Driving
_____ Yard Work	_____ Sleep	_____ Button/Tie/Zip	_____ Turning key	_____ Work
_____ Preparing meals	_____ Push/Pull	_____ Open a door	_____ Make bed	_____ Writing

_____ Other

Are you **Right** or **Left** handed? (circle one)

Pain Rating: Place an **"X"** over the number you rate your pain at **REST**
Place an **"O"** ove rthe number you rate your pain level with **ACTIVITY**

0	1	2	3	4	5	6	7	8	9	10
Mild					Moderate					Severe

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Name _____ **Patient Account #** _____

Consent For Treatment

I hereby give consent to Capitol Physical Therapy Associates, Inc. and its designated agents to provide evaluative and treatment services as necessary and reasonable for my care.

_____ _____

Signature (Or guardian if patient is a minor) Date

Authorization to Release Medical Information

I hereby authorize Capitol Physical Therapy Associates, Inc. to release any information necessary to process this claim.

_____ _____

Signature (Or guardian if patient is a minor) Date

Billing Policy

Capitol Physical Therapy Associates, Inc. as a service to our patients will submit your claim to your insurance company. Capitol Physical Therapy Associates, Inc. participates with most insurance companies *(see below). **You are responsible for any copays and/or deductible according to your individual policy. Please check with your insurance company for the details of your policy since ultimately you are the person responsible for the cost of treatment.**

As payments are received by us from your insurance company, we will bill you for any copays or deductible that may apply. Please make payment as you receive each bill. A billing fee of $4.00 will be added for every duplicate statement sent for unpaid balances. If you know that paying your balance will be a hardship, please contact our billing office to work out payment arrangements. If it becomes evident that no effort is being made towards payment, your bill will be turned over to a collection agency.

I have read and UNDERSTAND the above and agree to accept responsibility for any balance on my account that is not payable by my insurance company. I give Capitol Physical Therapy Associates, Inc. permission to bill my insurance company on my behalf.

_____ _____

Signature (Or guardian if patient is a minor) Date

***Not all insurance companies are willing to pay for rehabilitation services at Capitol Physical Therapy Associates, Inc. Again, please check with your insurance company regarding any stipulations.**

Acknowledgement of Notice of Privacy Practices

I have received and read the Notice of Privacy Practices of Capitol Physical Therapy Associates, Inc. You may request a copy.

_____ _____

Signature (Or guardian if patient is a minor) Date