COASTAL HAND & OCCUPATIONAL THERAPY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver Lic #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occurred at: Work Auto Home Other Date of injury or symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly explain how injury occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a follow up appointment? YES NO Date of next appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Information

If Minor Responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF WORK RELATED Employer Ins.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there an Attorney involved in your case? YES NO If Yes Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE READ AND INITIAL BELOW:

\_\_\_\_\_\_ All copays and deductibles must be paid at the time of service. As part of our contract with the insurance companies we are legally required by the terms of the contract to collect any copays at the time of service.

\_\_\_\_\_\_CHOT/BCPT will submit a claim for the patient to contracted insurance carriers. HOWEVER, ANY SERVICES NOT COVERED BY THE INSURANCE WILL BE THE PATIENTS RESPONSIBILITY.

\_\_\_\_\_\_I have read and understand the notice of privacy practices (HIPAA) and Notice of Patient Information Practices for CHOT/BCPT.

\_\_\_\_\_\_I understand that I will be responsible for a $45 NO SHOW fee. We also require a 24 HOUR CANCELLATION notice failure to do so will result in a $45 charge. This will not be covered by your insurance carrier you are responsible for this charge. Also if you are 15 min. late to your apt this may be counted as a “NO SHOW” and could result in a $45 charge.

\_\_\_\_\_\_I understand there is a $25 charge for a return check that is payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a “cash only basis” following any returned checks.

\_\_\_\_\_\_In case of a workers’ compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, as well as name and address of the insurance carrier prior to your visit. If this information is not provided, you may be asked to either reschedule your appointment or pay for your visit at the time of service.

\_\_\_\_\_\_It is our office policy that if your acct is over 90 days overdue, you will receive a final notice letter stating you have 15 days to pay your acct in full. Partial payment is not accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your acct to a collection agency and you may be discharged from the practice.

\_\_\_\_\_\_I hereby consent to bill my health ins. Carrier directly, or from another insurer for the services provided to me. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and authorizations of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management, collection purposes and related healthcare data processing through this practice. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I have read and understand the payment policy for CHOT/BCPT and agree to abide by these guidelines.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_