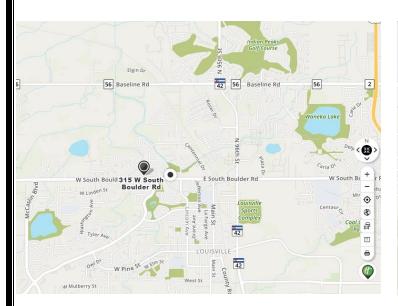
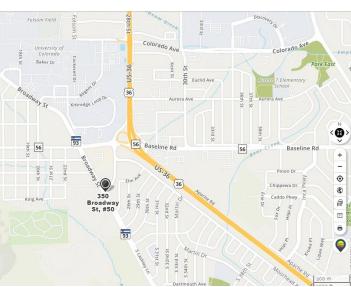


phone: 303 666 4151 | fax: 303 666 4166 wwww.coalcreekpt.com | coalcreekpt@gmail.com

## **Welcome to Coal Creek Physical Therapy!**

Thank you for choosing us as your physical therapy provider. We have enclosed our New Patient Intake Packet. Please fill out the forms, front and back, and bring them with you to your first visit. If you have any questions, we will be more than happy to answer them. Please allow 10-15 minutes for check-in before your appointment time. We are looking forward to meeting you and helping you get back to feeling better and living a life you love!





## **LOUISVILLE LOCATION**

315 W. SOUTH BOULDER ROAD #100 + #209 | **LOUISVILLE, CO** | 80027

## **BOULDER LOCATION**

350 BROADWAY STREET #50 | **BOULDER, CO** | 80305

## **WELCOME TO COAL CREEK PHYSICAL THERAPY!**

Thank you for selecting our healthcare team at Coal Creek Physical Therapy. Please fill out this form completely. Please ask a front desk staff member if you have any questions or need help. IF YOU ARE A RETURNING PATIENT, PLEASE INFORM US OF ANY CHANGES TO YOUR INFORMATION OR INSURANCE.

| <u>Patient Information</u>                               |                          |                  |                           |                       |  |
|--|--------------------------|------------------|---------------------------|-----------------------|--|
| Full Name:   | G                        | oes By:          | DOB:                      | Sex: M/F              |  |
| Street Address:  | City:                    | Sta              | te:Zip:                   |                       |  |
| Phone (home):  | Phone (cell)             | <u>:</u>         | Phone (Work):_            |                       |  |
| SS#:   | E-Mail Addre             | ess:             |                           |                       |  |
| Referring Physician Name:_                               | Primary Care Provider:   |                  |                           |                       |  |
| <b>Emergency Contact</b>                                 |                          |                  |                           |                       |  |
| Name:  | _Relationship to you:_   |                  | Phone Number(s            | s):                   |  |
| <b>Employer Information</b>                              |                          |                  |                           |                       |  |
| Employer:  | Employer Phone           | <u>:</u>         | Occupation:               |                       |  |
| Employer Address:  | City/State:              |                  | Zip:                      |                       |  |
| Brief Medical History                                    |                          |                  |                           |                       |  |
| Reason for your visit today:                             |                          |                  |                           |                       |  |
| Any other complaints you'd                               | d like to discuss?       |                  |                           |                       |  |
| Current Prescription Medica                              | ations                   | Prescribing      | g MD                      |                       |  |
|  |                          |                  |                           |                       |  |
| *If your medications exceed t                            | he space provided, plec  | se ask the front | desk staff for an extra 1 | Medications list form |  |
| Known Allergies:   |                          |                  |                           |                       |  |
|  |                          |                  |                           |                       |  |
| Acknowledgement of Rece                                  | eipt of Notice of Privac | <u> Practice</u> |                           |                       |  |
| I have received the Notice form at coalcreekpt.com u     | •                        |                  | , , ,                     |                       |  |
| Signature <b>X</b>                                       |                          | Dc               | ıte:                      |                       |  |
| General Request for Conse                                | nt to Physical Therapy   | <u> </u>         |                           |                       |  |
| By signing below, I am herb<br>treatment to be performed |                          |                  |                           |                       |  |
| Signature <b>X</b>                                       | ature <b>X</b> Date:     |                  |                           |                       |  |
|  |                          |                  |                           |                       |  |

| ls your coi            | <u>n <b>Information</b></u><br>ndition due to an c   | ccident? Y/N           | Date of accident (if applicable):   |  |  |
|------------------------|--|------------------------|---|--|--|
| Type of a              | ccident: <b>Auto/Wor</b>   | k/Home                 | If other, please qualify:   |  |  |
| Did you fil            | e a claim? <b>Y/N</b>  |                        | Contact Number:   |  |  |
| Do you ho              | ave an attorney?   | Attorney's Name:_      | Contact Number:   |  |  |
| <u>Assignme</u>        | ent of Benefit Info  | <u>rmation</u>         |   |  |  |
| submit clo<br>expected | aims, but would like   | you to understand o    | apy. We will work with you and with your insurance carrier to ur office policy regarding insurance assignment. Payment is ayment arrangements have been made. We ask that you |  |  |
| You ackno              | owledge that it is y   | our responsibility to: |   |  |  |
| 1.                     |  |                        | ntion on medical insurance coverage for yourself (or if the insurance card at the time of service.  |  |  |
| 2.                     | Pay applicable co-payment and deductible at the time of service.   |                        |   |  |  |
| 3.                     | Present a valid referral or authorization number for all services (if required by your insurance company). Your primary care physician or referring specialist can help you if needed.                             |                        |   |  |  |
| 4.                     | Inform us if the patient's need for medical services is due to a motor vehicle, worker's compensation, or other accident.  |                        |   |  |  |
| 5.                     | Provide health insurance information or other means of payment if motor vehicle orworker's compensation claims are denied, and accept any financial responsibility for any charges not covered by this assignment. |                        |   |  |  |
| 6.                     | Make payment within 30 days on any balance on your account for amounts due such as deductibles, coinsurance, co-payments, or non-covered services.   |                        |   |  |  |
| 7.                     | Verify that this pro   | ovider is in network w | ith your particular insurance plan under your insurance carrier.  |  |  |
|                        | ltimately responsible of benefits in wh  |                        | I bill if your insurance company does not honor the   |  |  |
| Your signo             | ature below indicat  | es:                    |   |  |  |
| 1.                     | You understand and accept our policy of assignment of insurance benefits.  |                        |   |  |  |
| 2.                     | You attest to the accuracy and completeness of the medical insurance coverage information.   |                        |   |  |  |
| 3.                     | You authorize this appeals.  | office to release me   | dical information necessary to process your claims and  |  |  |
| 4.                     | You authorize pa   | yment of medical be    | nefits to Coal Creek Physical Therapy.  |  |  |
|                        |  |                        | Date:   |  |  |

| <u>Claims:</u>  |   |
|---|---|
| I authorize Coal Creek Physical Therapy the right all dates of service.   | to submit both electronic and/or paper claims for   |
| Signature X   | Date:   |
|   |   |
| Message Release & Appointment Reminders:  |   |
| 1. I would like Coal Creek Physical Therapy to se   | end me automated appointment reminders via:   |
| *Please note that when you receive an appointment remind  | Text Message <b>OR</b> Voice Call der, it means that you are scheduled in our system. If you confirm. If you do not show up to the appointment and have |
| 2. I authorize Coal Creek Physical Therapy to lea   | ave messages which may contain personal health  |
| Information on this Phone#:   | E-mail Address:   |
| Signature X   | Date:   |
| schedule them. We require <b>24 hours advance</b> no for an EMG or Ultrasound appointment. We have message. If we do not receive this notice you will <b>\$95.00</b> for a <b>45 minute appointment</b> , <b>\$130.00</b> for a <b>appointment</b> . We provide appointment reminder reminder and miss an appointment, you are still recovered by or billed to your insurance and must Weather, illness, or emergency do not apply. You policy. | esponsible for the above fees. This charge is <b>NOT</b> be paid before your next scheduled appointment. or signature indicates that you understand our |
| Signature X   | Date:   |
| Supplies and Equipment  |   |
| I understand that Coal Creek Physical Therapy do<br>company to provide supplies, orthotics, braces, on<br>my insurance will not be billed, I agree to pay for   | equipment, or any durable medical goods. Since  |
| Signature X   | Date:   |
| Release of Information  I do/do not (please circle one) authorize Coal Cr medical records, x-rays, or reports to/from transfer and  |   |
| treatment. Signature X  | Date:   |
|   | this form! Please return it to the front desk staff.  |