

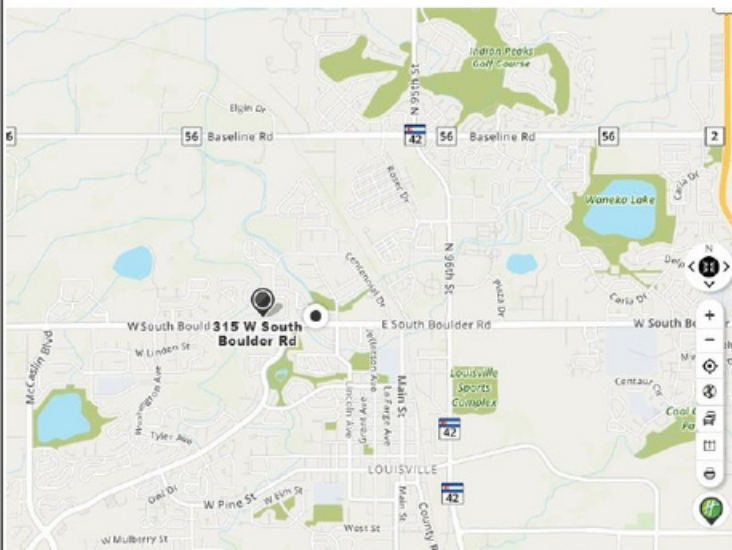
# Coal Creek Physical Therapy



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www.coalcreekpt.com | coalcreekpt@gmail.com

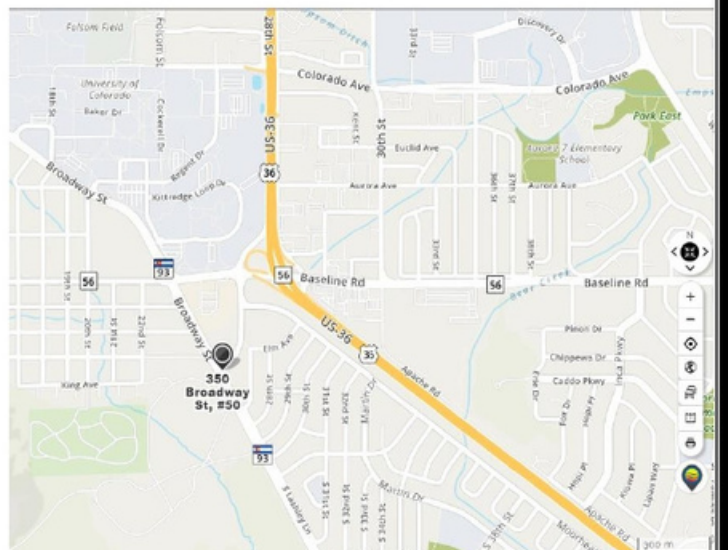
## Welcome to Coal Creek Physical Therapy!

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.**

### Patient Information

Full Name: \_\_\_\_\_ Goes By: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M/F

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_ Phone (Work): \_\_\_\_\_

SS#: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

### Employer Information

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Brief Medical History

Reason for your visit today: \_\_\_\_\_

Any other complaints you'd like to discuss? \_\_\_\_\_

Current Prescription Medications \_\_\_\_\_ Prescribing MD \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*If your medications exceed the space provided, please ask the front desk staff for an extra Medications list form.

Known Allergies: \_\_\_\_\_

\_\_\_\_\_

### Acknowledgement of Receipt of Notice of Privacy Practice

I have received the Notice of Privacy Practices from Coal Creek Physical Therapy, either in electronic form at coalcreekpt.com under Forms > Privacy Policy, or in paper form in our office.

Signature **X** \_\_\_\_\_ Date: \_\_\_\_\_

### General Request for Consent to Physical Therapy Treatment

By signing below, I am hereby requesting and consenting to a physical therapy evaluation and treatment to be performed by a physical therapist, therapist's designees, or assistants.

Signature **X** \_\_\_\_\_ Date: \_\_\_\_\_

Please read and sign all of the following statements. If you have any questions about them, we would be happy to assist you.

**Condition Information**

Is your condition due to an accident? **Y/N**                      Date of accident (if applicable): \_\_\_\_\_

Type of accident: **Auto/Work/Home**                      If other, please qualify: \_\_\_\_\_

Did you file a claim? **Y/N**      Adjuster's Name: \_\_\_\_\_      Contact Number: \_\_\_\_\_  
Claim Number: \_\_\_\_\_

Do you have an attorney?      Attorney's Name: \_\_\_\_\_      Contact Number: \_\_\_\_\_

**Assignment of Benefit Information**

Thank you for choosing Coal Creek Physical Therapy. We will work with you and with your insurance carrier to submit claims, but would like you to understand our office policy regarding insurance assignment. Payment is expected at the time of service unless previous payment arrangements have been made. We ask that you read and sign the following.

You acknowledge that it is your responsibility to:

1. Provide the complete, current information on medical insurance coverage for yourself (or if the patient is under 18), including a valid 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 or worker'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 provider is in network with your particular insurance plan under your insurance carrier.

You are ultimately responsible to pay the medical bill if your insurance company does not honor the assignment of benefits in whole or in part.

Your signature below indicates:

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 office to release medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to Coal Creek Physical Therapy.

Patient or Responsible Party Signature **X** \_\_\_\_\_ Date: \_\_\_\_\_

(Responsible Party, Relationship to patient): \_\_\_\_\_

**Claims:**

I authorize Coal Creek Physical Therapy the right to submit both electronic and/or paper claims for all dates of service.

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

**Message Release & Appointment Reminders:**

1. I would like Coal Creek Physical Therapy to send me automated appointment reminders via:

\_\_\_\_Email and: \_\_\_\_Text Message **OR** \_\_\_\_Voice Call

*\*Please note that when you receive an appointment reminder, it means that you are scheduled in our system. If you believe the appointment is an error, please CALL us ASAP to confirm. If you do not show up to the appointment and have not called, you will be charged a fee as listed below.*

2. I authorize Coal Creek Physical Therapy to leave messages which may contain personal health

Information on this Phone#: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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

**Late Cancellations and Missed Appointments:**

We may have patients waiting for your appointment time and your courtesy phone call allows us to schedule them. We require **24 hours advance** notice to cancel your PT appointment and **48 hours for an EMG or Ultrasound appointment.** We have a 24-hour answering service on which to leave a message. If we do not receive this notice you will be charged **\$85 for a 30 minute appointment, \$130.00 for a 45 minute appointment, and \$170.00 for a 60 minute appointment.** We provide appointment reminders as a courtesy. Should you not receive a reminder and miss an appointment, you are still responsible for the above fees. This charge is **NOT** covered by or billed to your insurance and must be paid before your next scheduled appointment. Weather, illness, or emergency do not apply. Your signature indicates that you understand our policy

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

**Supplies and Equipment**

I understand that Coal Creek Physical Therapy does not have a contract with my insurance company to provide supplies, orthotics, braces, equipment, or any durable medical goods. Since my insurance will not be billed, I agree to pay for these at the time of service.

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

**Release of Information**

I **do/do not** (please circle one) authorize Coal Creek Physical Therapy to release/obtain my medical records, x-rays, or reports to/from \_\_\_\_\_ (physician's name) pertaining to my treatment.

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

**Thank you for taking the time to fill out this form! Please return it to the front desk staff.**