Creative Therapeutics 400 E Hillcrest Dr., Ste 110 DeKalb, IL 60115

Thank you for choosing our office! In order to serve you properly, we need the following information.

All information will be kept confidential.

Please Print

Patient Name: Last, First, Middle Initial				Today's Date:	
Home Address:		City:		State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	Email Address:		
Birth Date:	Social Security #:		Height:	Weight:	Gender: M F
Circle Appropriate: Minor Single Partner Married Divorced Seperated Widowed					
Person to contact in case of emergency:		Their relationship to you:		Phone Number:	
Patient's Occupation:	Employment Status:		Family Doctor:		
Referring Physician:					
How did you hear about us? If we need to reach you, can we email or use your cell? May we send you our email newsletter?					

Insurance Information

Insurance Company:	Spouse SS# if policy holder:		
Patient's (or patient/guardian's) Employer:			
Business Address:	City:	State:	Zip:
Spouse (or parent/guardian's) Name:	Spouse's Occupation:		
Spouse (or parent/guardian's) employer:	Spouse's Work Phone:		
Spouse Birth Date:	Policy Holder:	Policy Number#:	
Relation to insured:	Insurance Phone #:		
Secondary Insurance:	Secondary Insurance Policy Number:		

I certify that the above information is accurate

Signature _____ Date _____

If this is a worker's comp claim, please complete the following:

Did you report this incident to your employer? Yes No	Date of Injury:	Company Contact Phone Number:
Is your employer aware that you are seeking treatment? Yes No	Company Contact Person:	
Place of Employment:	Human Resources Representative for Company:	
Insurance Company:	Insurance Company Phone Number:	
Case Number:	Please add any information we should know about case:	

If this is a motor vehicle accident, please fill out the following:

Date of Injury:	State in which accident took place:
Insurance Company:	Policy Holder:
Policy Number:	Claim Number:
Contact Person:	Contact Phone Number:
Is this your insurance or other party's insurance?	3rd Party Name:
3rd Party Phone:	3rd Party Address:
3rd Party City, State, Zip	

Important information regarding your accident: It is unfortunate you have been hurt in a motor vehicle accident. The insurance company for the responsible party appears to be liable for your treatment; however, you are responsible to us for the payment of your treatment should your insurance company deny payment.

If your insurance company is not paying your claims as you receive treatment (holding for all treatment to be finished and signed off on) Creative Therapeutics requires payment at each appointment. Full payment would be appreciated, but you must pay at least a portion of your payment for each treatment.
Any charges that are not paid by your insurance company in a timely manner will be billed and due from you.

Signature _____ Date _____

FINANCIAL POLICY

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your signature is required at the bottom of the page. Thank you.

- **Private Pay** – (clients without insurance) Full payment is required when services are rendered to continue treatment OR payment arrangements need to be agreed upon.
  Insurance Company Reimbursement – Clients are required to contact their insurance company to verify their deductible status and the amount of coverage for physical therapy available to them. We will also be contacting your insurance company to verify your coverage. **It is important to remember that what the insurance company tells us is not a GUARANTEE of payment from them.**
- **Deductible and Co-payment -** If you have not previously met your deductible, payment is due in full for your initial evaluation at the time of your first visit. If you have not met your deductible, you will be required to pay the full amount of each visit until you have met it**. We require your co-payment or co- insurance at the time of service.** If you do not know what your co-insurance is, a minimum of 20% is due at the time of service. Any charges that your insurance company does not pay for or denies will be the patient's responsibility.
- **Purchasing products – payment for all products are the patient's responsibility**. Payment for products is due at the time of purchase.
- **Worker's Compensation** – All pre-authorized bills will be sent directly to your Worker's Compensation carrier. **If your claim is denied or disputed, you will be responsible for payment** and a payment plan will be arranged.
- **Auto Accident -** You must supply us with the insurance company who is responsible and a contact person. **If they do not pay in a timely manner, or are waiting until the accident is completely settled to make payment - you will be responsible for payment at the time of service.**

AGREEMENT TO PAY

I understand that the agreement with my health insurance, worker's comp carrier or auto accident insurance is an agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy detailed above. **I understand that I am responsible for all charges regardless of my existing medical coverage.**
A fee of $25.00 will be charged for cancellation of my appointment without 12 hours notice or failure to attend a scheduled appointment. NSF checks will be charged a $25.00 fee.

Consent for Treatment/Release of Insurance Assignment Medical Information

YES_____NO_____I authorize any and all therapy service that the provider feels necessary or advisable in conjunction with my referral.

YES_____NO_____I assign payment of medical benefits directly to Creative Therapeutics, Ltd.

YES_____NO_____ I hereby authorize Creative Therapeutics, Ltd. to release to my insurance company, health plan, or insurance group, any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by Creative Therapeutics, Ltd. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditioned on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying for all services rendered by Creative Therapeutics, Ltd.

I have read, understand and agree to this financial agreement.

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SIGNATURE **DATE**