CTS PHYSICAL THERAPY

CONTEMPORARY THERAPEUTIC SOLUTIONS

Patient Information

Date: _____ Record # _____

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone ( ) _____ SS#_____ Marital Status: S M

Cell Phone ( ) _____ E-Mail: _____

Who referred you to us? _____

Employment Status: Employed Unemployed Retired Student

Employer: _____ Employer Phone ( ) _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Primary Insurance: _____ Secondary Insurance: _____

Policy No: _____ Policy No: _____

Insured Name: _____ Insured Name: _____

Insured SS No: _____ Insured SS No: _____

Insured Date of Birth: _____ Insured Date of Birth: _____

Insurance Authorization / Responsibility Agreement / Consent to Treat

I hereby authorize any insurance company to pay the proceeds of any benefits due to me directly to: Contemporary Therapeutic Solutions, 310 Simmons Road, Suite J, Knoxville, TN 37922.

I acknowledge and understand that I am responsible for all charges for all of the services rendered to me or to any member of my family, even though I requested insurance billing on my behalf. I agree to make payment in full of any portion not paid by insurance promptly, unless otherwise arranged with the Business Manager. Collection fees/Legal Fees will be added to the balance of my account referred to collection and I agree to pay 35% (thirty-five percent) in collection agency fees. I also hereby give permission for the collection agency to report and to pull a credit bureau report in the event the account becomes delinquent.

I have personally or through my physician requested rehabilitative services. I hereby authorize release of medical records to other medical agencies or my attorney as necessary.

I certify that the information given to file for Medicare payment is correct and request such payment be made directly to Contemporary Therapeutic Solutions.

Patient's Signature: _____ Date: _____