Welcome Letter

Dear New Patient,

Welcome to Carousel Physical Therapy! Our goal is to help you get better! To do this, we need a few things from you:

A Commitment of Attendance to Your Therapy Sessions.

- Missing appointments can delay your recovery.
- No-shows and last-minute cancels may result in a fee.
- In an emergency, try to give notice as soon as possible.

Regular Completion of Your Home Program.

Doing your home program as often as prescribed by your physical therapist (PT) is essential to your recovery. Including:

- Completing your PT issued Home Exercise Program (HEP) as prescribed.
- Following any recommended modifications, or restrictions to activities or certain movements.

(If instructions are unclear, call them or ask for further explanation at your next treatment.)

Remember you will get out of your physical therapy sessions what you put into them!

Thank you for choosing Carousel! We are excited to work with you and your physician on achieving your goals for therapy!

Sincerely,
CPT Staff

KILMARNOCK: P.O. Box 128/ 500 Irvington Road ● Kilmarnock, VA 22482 ● 804-435-3435
HARTFIELD: 10880 General Puller Hwy, Suite N ● Hartfield, VA 23071 ● 804-776-8500
email: carousel@carouselpt.com ● **web:** carouselpt.com

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Insurance Coverage

- **We have verified your insurance coverage prior to beginning your therapy and will give you an explanation of your coverage.**
- **All claims are submitted to primary, secondary, and tertiary insurance carriers. Your insurance coverage is an agreement between you and your insurance company. It is your responsibility to remit payment for charges not covered by your insurance carrier.**
- **If you would like an estimate of the total cost of your sessions, your therapist will supply you with an estimate based on your insurance coverage. Realize this is only an estimate. Charges can vary depending on the procedures completed. If you have any questions regarding your insurance, please speak with our Financial Manager as she can provide you with further explanation of your insurance benefits.**

Co-Pays and Payments

- ***We expect you to pay your co-pays at the time of your visit and to pay the balance due at the end of each series of treatments.***
- **If there is a balance after all insurances have paid, you will receive a statement which is due and payable within 30 days of the statement date.**
- **For your convenience, you may pay by cash, check, money order, Visa and Master Card.**
- **If you cannot pay your bill in full upon receipt, our financial manager would be happy to make arrangements for a payment plan. Both parties will sign a written agreement. Once acceptable financial arrangements have been made, it is imperative that you adhere to the arrangements.**

Fees

- **A two (2%) percent service charge is applied every 30 days until paid in full.**
- **A $25.00 dollar fee will be charged for all returned checks.**
- **There is a $50.00 no show/ cancellation fee charged if we are not properly notified.**
- **In the event that it is necessary to collect a balance through court procedures, you will be responsible for attorney fees and court costs.**

Medicare Patients

- **Medicare covers 80% of the cost of your physical therapy after your yearly deductible has been met. If you have a secondary insurance, we will file the remaining balance to your secondary insurance.**
- **If you do not have a secondary insurance or your secondary insurance does not cover all of your therapy, you will be responsible for the balance.**

BY LAW, ALL PATIENT ACCOUNTS ARE DUE AND PAYABLE WITHIN 30 DAYS OF SERVICES RENDERED

Care that Revolves Around You!

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Medical History

PATIENT NAME:_______________________________________ **D.O.B.:**________________________

Height:____________________ **Weight:**__________________ **Hand Dominance:**_____________

Please check all conditions that apply:

___Diabetes
___High Blood Pressure
___Heart Disease and/or ___Stroke
___High Cholesterol
___Stomach/Intestine Problems
___Tobacco Usage
___Circulatory Problems
___Kidney/Renal Problems
___Hepatitis
___Rheumatoid arthritis
___Asthma
Other:____
___Depression
___Cancer
___Lung Disease
___Osteoarthritis
___Osteoporosis (brittle bones)

<u>ALLERGIC:</u> Known Drug/Latex Allergies? Please provide

____

Have you had any Diagnostic Tests related to your problem? Circle all that apply

X-RAY MRI/MRA CT scan Other____

Have you had any SURGERIES, MAJOR INJURIES or TRAUMAS in the past 20 years?
Please list:

____
____
____

MEDICATIONS you are currently taking? (Prescription & Over the Counter)
(MEDICARE Patients: Please include dosage, frequency, route-ie. mouth, topical)

____
____
____

Have you had any Falls in the past YEAR? Please circle one: YES/NO. IF <u>YES</u>, please list all:
Where?____Date of fall:___________
Where?____Date of fall:___________

Has any medical care ever been provided INSIDE your home (ie. physical/occupational therapy, nursing, wound care, etc.)? **Please circle one: YES/NO.** If <u>YES</u>, what service and date it was provided?
Service:____ Date:___________

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