STERLING
PHYSICAL THERAPY & WELLNESS
A COMPANY OF CARTERA HEALTH

New Patient Registration Packet

Past Patient ☐ **Yes** ☐ **No**	**Today's Date:**

Patient Information

verified DL/photo i.d:. ☐ Yes ☐ No

Last Name/Suffix	First Name			Middle Initial
Address: Apt/Bldg:	City		State:	Zip Code:
Home Phone Contact Method: Ph☐ E-m☐ Mob☐ Txt☐	Mobile Phone		Email Address No Appointment Reminders☐	
Date of Birth	SSN	Sex: ☐ M ☐ F	Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Unknown	

Employer Information

Employer Name:	Employment Status: ☐None ☐FT ☐PT ☐Self-Emp. ☐Retired ☐Student		
Address:	City	State:	Zip Code:
Work Phone Number	Patient Occupation		

Emergency Contact Information

Contact Name:	Phone #	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Physician Information

Name of Referring Physician:	Telephone #:	☐Patient Has Referral ☐Referral Faxed to SterlingPT

Additional Questions

Date of Injury Onset Date:	Auto Related: ☐ Yes-State? _____ ☐ No **Adjuster name:** _____ **Phone #:**_____	Work Related: ☐ Yes ☐ No	Accident Related: ☐ Yes ☐ No	Diagnosis/Body Part:

Attorney Involved: ☐ Yes ☐ No	Attorney Phone#: _____
Attorney Name: _____	Attorney Fax #: _____
Have you had any prior Therapy this year? ☐ Yes ☐ No (Physical Therapy | Occupational Therapy | Speech Therapy | Chiropractic)	How did you hear about us?

MEDICARE ONLY- Additional Questions

If Medicare, are you currently receiving Home Health Service? ☐ Yes ☐ No If yes, Name of Agency ? _____

If Yes, what type of Home Health Services are you receiving? _____

Last Date of Service _____

If Medicare, have you received PT, OT or Speech services since the first of the year? ☐ Yes ☐ No

- If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐ Yes ☐ No
- Are you aware of any partial amount used since the first of the year? $_____.
- If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

Appointment Date:	Time:	Therapist:

Intake Completed By: _____ Date:_____	**Patient, Please initial here if the above information is complete and correct _____Date:_____**

Last Name/Suffix	First Name

Insurance Information

☐ Sugar Land Clinic	☐ Houston Clinic - OakBend	*Policy holder is not the patient?* **Primary** **Secondary**
NPI (Facility) - 1471114364 Dr. Sterling Carter - 1184672206 Dr. Lakshmi Urlam - 1578806816	NPI (Facility) - 1700883196 Dr. Sterling Carter - 1184672206 Dr. Kevin Klecka - 1841697877	Subscriber's Name | Subscriber's SSN | DOB **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Child ☐ Other
Tax ID - 262630132	Tax ID - 760339462	Employer Name & Phone #:

PRIMARY INSURANCE ☐ In-Network ☐ Out-of-Network	**SECONDARY INSURANCE** ☐ In-Network ☐ Out-of-Network
Payor/Plan Type *(PPO, HMO, POS, Replacement, Supplement)*:	Payor/Plan Type *(PPO, HMO, POS, Replacement, Supplement)*:
Policy/ID #: | Group #:	Policy/ID #: | Group #:
Insurance Phone #:	Insurance Phone #:
INSURANCE VERIFICATION	**INSURANCE VERIFICATION**
Date: | Spoke with:	Date: | Spoke with:
Effective Date: _____ End Date: _____ Is this a Federally Funded Plan? ☐ Yes ☐ No	Effective Date: _____ End Date: _____
Does patient have PT coverage? Yes ☐ No ☐	Does patient have PT coverage? Yes ☐ No ☐
Informed Payor this is outpatient therapy performed in an office setting. ☐	Informed Payor this is outpatient therapy performed in an office setting ☐
Visit Limitation: | Coinsurance: %	Visit Limitation: | Coinsurance: %
Approved CPT Codes ☐ 97012 ☐ 97032 ☐ 97035 ☐ 97110 ☐ 97112 ☐ 97113 ☐ 97116 ☐ 97140 ☐ 97530 ☐ 97535 ☐ 76881	Approved CPT Codes ☐ 97012 ☐ 97032 ☐ 97035 ☐ 97110 ☐ 97112 ☐ 97113 ☐ 97116 ☐ 97140 ☐ 97530 ☐ 97535 ☐ 76881
Comments/Special Instructions:	Comments/Special Instructions:
Deductible: $ Met: ☐ Yes ☐ No | Out Of Pocket: $ Met: ☐ Yes ☐ No	Deductible: $ Met: ☐ Yes ☐ No | Out Of Pocket: $ Met: ☐ Yes ☐ No
Does patient have a co-pay? ☐ Yes ☐ No If yes, amount: $ Per Visit? ☐ IE/Re-eval only? ☐	Does patient have a co-pay? ☐ Yes ☐ No If yes, amount: $ Per Visit? ☐ IE/Re-eval only? ☐
Required for therapy? ☐ PCP ☐ Authorization ☐ Pre-Cert ☐ e-Referral	Required for therapy? ☐ e-Referral ☐ Authorization ☐ Pre-Cert
Claims Address:	Claims Address:

Verification (Workers Compensation)

Is this a ☐ State Funded or ☐ Self Insured plan (call employer) Plan Name: _____

Claim Number: _____ Dx Codes on file: _____

☐ Allowed ☐ In Process ☐ Pending ☐ Hearing ☐ Other

Adjuster Name:_____ Adjuster Phone:_____

Adjuster Fax:_____ Adjuster Email:_____

Nurse/Case Manager Name: _____ Nurse/Case Manager Phone:_____

Nurse/Case Manager Fax:_____ Nurse/Case Manager Email:_____

Additional Notes:

Verified By:_____ **Date:**_____

Patient Medical History Form

Patient's Name: _____ Gender: ☐ Male ☐ Female Date: _____

Referring Physician: _____ Return Visit Date: _____

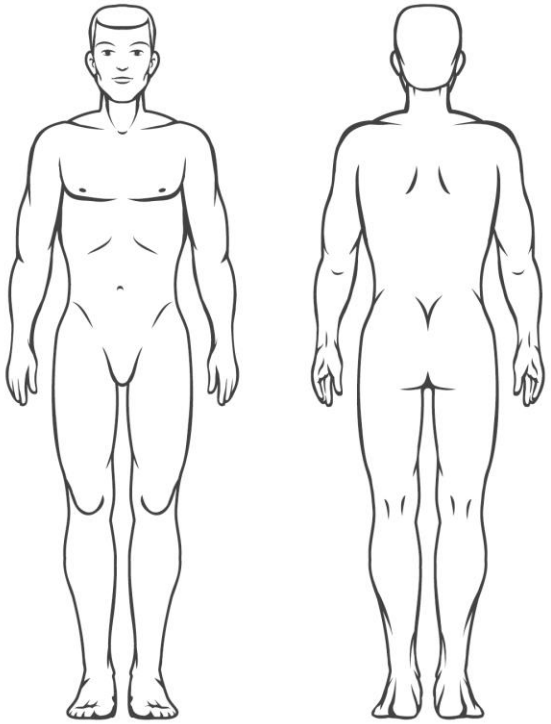
Body Part: _____ Injury Date: _____ Surgery Date: _____

Type of Surgery: _____

What is the nature of your current injury?

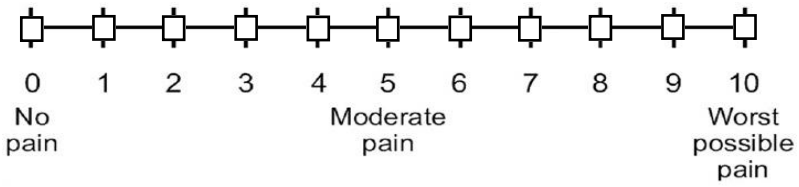
☐ Work Related ☐ Chronic / Reoccurring ☐ Fall ☐ Motor Vehicle Accident
☐ Recreational ☐ Lift or Carry ☐ Insidious ☐ Surgery

Please use the diagram to mark the location of symptoms.



What is your pain rating in the last 24 hours?

0 – 10 Numeric Pain Intensity Scale



My symptoms are:

☐ New ☐ Constant ☐ Intermittent ☐ Chronic

My symptoms are made better by?

_____

My symptoms are made worse by?

_____

Are your work or activities of daily living limited?

☐ Yes ☐ Partial ☐ No

Past Medical History

Have you ever been diagnosed with any of the following? *(check all that apply)*

☐ Allergies (medicine / food / latex)
☐ Arthritis
☐ Cancer / Tumor
☐ Chest Pain
☐ Chronic Headaches
☐ Congestive Heart Failure
☐ Diabetes Type I / Type II
☐ GI Disease
☐ High / Low Blood Pressure
☐ Lung Disease / COPD
☐ Metal in Body
☐ Neurological Disease
☐ Osteoporosis
☐ Pacemaker
☐ Pneumonia
☐ Pregnant (currently)
☐ Respiratory Problems
☐ Seizures / Epilepsy
☐ Stroke / CVA / TIA
☐ Thyroid Problems

Medications

Please see attached lists provided by the patient.

Prescription / Over the Counter / Vitamins	Frequency	Dosage

STERLING PHYSICAL THERAPY & WELLNESS
FINANCIAL POLICY & PATIENT RESPONSIBILITY

Sterling Physical Therapy & Wellness (SPTW) thank you for choosing us! We are committed to providing our patients with the highest quality care. We thank you for taking the time to read and understand our policy.

Self-Pay & Non-Contracted Plans:

All charges are due and payable at the time of service. We accept cash, checks, and major credit cards. We may reschedule the appointment if payment is not made prior to the services rendered.

Insurance Contracted Plans (Patients with Insurance):

It is the Patient's Responsibility…

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan and covered, non-covered benefits, **authorization requirements**, and **cost share information** such as deductibles, coinsurances, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To determine whether a referral is required from your Primary Care Physician (PCP). If the patient does not obtain a referral from their PCP prior to receiving services or a referral cannot be verified by our offices, the patient has the option of re-scheduling the appointment.

  If the patient decides to keep the set appointment and/or receive services, it is with the understanding that their health plan may not pay for charges related to the services provided by Sterling Physical Therapy & Wellness and that without a referral, the patient would be responsible for payment of all charges.
- Any non-covered services, as determined by the patient's insurance carrier, are the financial responsibility of the patient.
- To pay their co-payment or deductible at the time of service. Finance charges are accrued monthly on unpaid balances and are the responsibility of the patient.

  Prior to your first visit, we will contact your insurance company(s) to determine your out-of-pocket expenses. It is important for you to remember that this is an estimate based on your insurance benefits, and while we will do our best to give you the most accurate number. There are many variables which could change this number and additional charges that we cannot predict right now. If this does occur, we will send you a statement after we have received an Explanation of Benefits from your insurance company.
- To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.
- SPTW will submit a claim for the current services to the patient's insurance carrier. Insurance carries are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is required to pay SPTW for a service that has been provided, the patient will only be responsible for what is considered the patient portion of the claim.

  However, if the insurance carrier rejects, delays, withholds, denies payment of its portion or covers only a portion of treatment for more than 90 days from the date of service, both the insurance and patient portions of the account then becomes the patient's responsibility. If we subsequently receive payment from the insurance carrier, we will credit the patient's account for the amount of payment and issue a refund accordingly.
- To facilitate in claim payments by contacting their insurance carrier when needed.

It is Sterling Physical Therapy & Wellness' Responsibility…

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A 90-day period will be extended for pending insurance payments, after which, the patient may be held responsible for the balance.

Refunds:

- Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor.
- Patient refunds will not be processed until all active or past due accounts are paid in full (until all claims have been resolved).

Delinquent / Unpaid Account:

- Prior to providing services, payment of prior outstanding accounts will be requested and should be received. Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically urgent.
- Accounts which cannot be collected by SPTW after normal in-house collection procedures may be referred to a collection agency for further collection action in accordance with the SPTW's established guidelines. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty days (30) of billing.

No Show / Same Day Cancellation Policy

Our staff works hard to offer you an appointment that is convenient for you. We understand that there are times when you must miss an appointment due to emergencies or other obligations. If circumstances prevent you from keeping your appointment, please **call the office at least 24 hours in advance** to reschedule.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a thirty-dollar ($30) fee; this fee will not be covered by your insurance company.

In the event that you neglect to notify us 24 hours in advance or miss your scheduled appointment, a member of our SPTW staff will call to remind you of the miss appointment and offer you an opportunity to reschedule the appointment within the same business week. If we are unable to reach you on the day of the visit or you are unable to reschedule within the same business week, the inconvenience fee will be applied to the account and the patient will be invoiced.

Please understand that our policy is in place to assure that we maintain a superior standard of care for all of our patients. Additionally, missed appointments prevent us from caring for other patients that may need our services at that time.

Financial Policy Acknowledgement

I have read and understand the above financial policy. I understand that regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

Release of Medical Information and Assignment of Benefits

I authorize the release of medical information necessary for filling health insurance claims for me by Sterling Physical Therapy & Wellness. I also authorize my insurance carrier(s) to make payment directly to Sterling Physical Therapy & Wellness.

I acknowledge that I have read, understood and accept each paragraph stated above.

Patient (or Legal Guardian) Signature

_____ _____

Patient's Signature Date

STERLING
PHYSICAL THERAPY & WELLNESS
A COMPANY OF CARTERA HEALTH

Patient Financial Responsibility

What if I do not have insurance or you are not a participating provider for my carrier?

For patients who do not carry heath insurance and those for whom we do not accept their policy, payment will be expected in full at the time of the visit. Anyone who feels it is necessary to extend payments over a period of time is invited to discuss arrangements with us prior to their visit.

What are my financial responsibilities as a patient?

As a patient, it is in your best interest to know and understand your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill. If you do not notify our office of a change in coverage at the time of you appointment and your claim is denied as a result, you will be responsible for the charges of the claim in full.

To find out what your insurance plan covers and what your financial obligation may be, call the Customer Service or Member Services Department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Make sure that your insurance company lists your physician as a participating provider. It is possible that only one of our physicians participate with your insurance plan. Benefit and coverage rules and policies differ among insurers and even between different plans of the same insurer. If you go to an out-of-network provider, you may have a greater financial responsibility for services provided from a physician that is not under contract with your health care plan. Your insurance company can assist you in finding an in-network provider to limit the amount of money you will have to pay for care. Contact your plan's Customer Service department for further assistance.

What should I do if my insurance changes?

You are responsible to notify us of all changes to your insurance coverage. Please have your current insurance card with you at all times, as well as a photo ID such as a driver's license, military ID or government issued ID.

IF WE ARE NOT NOTIFIED OF APPROPRIATE CHANGES AT THE TIME OF YOUR VISIT, WE CANNOT GUARANTEE INSURANCE PAYMENT. IF YOUR CLAIM IS DENIED BECAUSE WE WERE NOT NOTIFIED AT THE TIME OF YOUR VISIT YOU WILL BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. INITIAL_____

Why are you asking for my deductible, co-insurance or co-payment at the time of my visit?

We ask that payments be made when you are at the physician office so you will not be bothered with an invoice sent to your home after your visit. It also helps us reduce our costs and saves you the trouble of mailing a payment back to our office.

What if my insurance plan requires a referral and/or a prior authorization?

If your insurance company requires a referral and/or prior authorization, contact your primary care physician prior your appointment in our office.

If your insurance company requires a referral and/or prior authorization and you do not have one, you may not be seen for your scheduled appointment, or you will be responsible for full payment of your bill at the time of service. If you require more than one visit for treatment or if the referral has expired, you must contact your primary care physician for another referral and/or prior authorization.

When can I expect to receive a bill? Why was I sent a statement when my insurance company is supposed to pay my bill?

For patients with health insurance, you are typically required to pay your portion of the bill at the time of service. Please note, you are paying and "estimate" at the time of service. Any balance due or credit will be sent to you within 30-60 days.

Whether you have insurance coverage or not, you as the patient are ultimately responsible to make sure your bill is paid. If you receive a statement showing that your insurance company has not paid, it may be helpful for you to contact your insurance company to ask why payment has not been made.

Where do I send payment? What methods of payment are accepted?

You can make payment in person or over the phone during our office hours, or you can mail payment to:

Sterling Physical Therapy & Wellness

Sugar Land Clinic	SW Houston Clinic
1449 Hwy 6, Suite 260	8323 Southwest Frwy, Suite 651
Sugar Land, TX 77478	Houston, TX 77074

Payment can be made with check, money order, cash, Visa MasterCard, Express or Discover. Checks should be made payable to Sterling Physical Therapy & Wellness. Please note there is a $50 service charge for all returned checks.

I _____ have read and thoroughly understand my financial responsibility for all services rendered. I am aware my insurance contract is between me and my insurance company and I will be billed by my provider for any services rendered not payable.

Signature_____ Date_____