**CAROLINA OCCUPATIONAL THERAPY**

1038 W. H. SMITH BLVD, UNIT 101

GREENVILLE, NC 27834-5051

(252) 757-1691

**DEMOGRAPHIC INFORMATION**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST MIDDLE

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEX: (CIRCLE) MALE – FEMALE MARITAL: (CIRCLE) SINGLE – MARRIED – WIDOWED – DIVORCED

DATE OF INJURY / ONSET \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF SURGERY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACCIDENT RELATED? YES – NO

AUTO ACCIDENT? YES – NO IF SO, WHICH STATE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK COMP? YES – NO

DO YOU HAVE A NURSE CASE MANAGER FOR THIS INJURY? YES – NO WHO? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE AN ATTORNEY FOR THIS INJURY? YES – NO WHO? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YOUR NEXT APPOINTMENT DATE \_\_\_\_\_\_\_\_\_\_ TIME \_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS CITY STATE ZIP COUNTY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET ADDRESS CITY STATE ZIP COUNTY  
HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER/SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT 1**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT 2**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

DIAGNOSIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAJOR MEDICAL CONDITIONS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS (IF YOU HAVE A LIST WE WILL BE HAPPY TO COPY THAT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICARE PATIENTS ONLY**

I ATTEST THAT I AM NOT CURRENTLY RECEIVNG HOME HEALTH SERVICES. I WILL INFORM THE OFFICE STAFF IMMEDIATELY IF THIS CHANGES. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF ANY CHARGES THAT MEDICARE DENIES BECAUSE OF HOME HEALTH SERVICES.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTINUED ON** BACK 🡪

**AUTHORIZATIONS/POLICIES – PLEASE READ, SIGN, AND DATE**

**PAYMENT AGREEMENT**: YOU ARE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED. PAYMENT IS REQUIRED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. ANY BALANCE REMAINING AFTER INSURANCE HAS PAID IS YOUR RESPONSIBILITY. ARRANGEMENTS MAY BE MADE WITH OUR PATIENT ACCOUNTS REPRESENTATIVE.

**ATTORNEY/COLLECTION FEES**: I UNDERSTAND THAT IF I FAIL TO PAY MY BILL AS AGREED UPON, I MAY BE RESPONSIBLE FOR ANY FEES THAT MAY BE INCURRED BY THE CREDITOR.

**AUTHORIZATION OF BENEFITS**: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS, INCLUDING ANY GOVERNMENT BENEFITS, ON MY BEHALF TO CAROLINA OCCUPATIONAL THERAPY FOR SERVICES.

**MEDICAL AUTHORIZATION**: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS TO THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND ITS AGENCY, OR TO MY INSURANCE COMPANY.

**NON-COVERED SUPPLIES**: I UNDERSTAND THAT CERTAIN SUPPLIES MAY NOT BE COVERED BY MY INSURANCE COMPANY. IF NOT, I WILL BE RESPONSIBLE FOR PAYMENT OF THESE SUPPLIES.

**LOANED EQUIPMENT**: I UNDERSTAND THAT IF I DO NOT RETURN EQUIPMENT THAT IS LOANED TO ME, I WILL BE BILLED FOR IT.

**SUPPLEMENTIAL INSURANCE POLICIES:** I WILL INFORM THE OFFICE STAFF IMMEDIATELY IF I OBTAIN A SUPPLEMENTAL INSURANCE OR ACCIDENT POLICY. I UNDERSTAND THAT I MAY REQUEST CPT CODES AND DATES OF SERVICE EVERY TWO WEEKS OR EVERY SIX VISITS, DEPENDING ON MY COURSE OF CARE.

**NO-SHOW FEE**: I UNDERSTAND THAT I MAY BE CHARGED A $30 FEE FOR NOT SHOWING UP FOR A SCHEDULED APPOINTMENT.

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIVACY PRACTICE ACKNOWLEDGEMENT**

I HAVE READ, AND I UNDERSTAND THE HIPPA NOTICE OF PRIVACY PRACTICE INFORMATION. I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT, AND KEEP A COPY SHOULD I SO DESIRE.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_