PATIENT INFORMATION

(Please complete in entirety)

Name _____ **Date** _____
(Last) (First) (MI)

Mailing Address _____ **Date of Birth** _____

City _____ **State** _____ **Zip** _____ **Gender** _____

Email _____ **Social Security Number** _____-_____-_____

Home Phone _____ **Cell Phone** _____

Marital Status: Single _____ **Married** _____ **Name of Spouse** _____

Emergency Contact: Name _____ **Phone** _____

Patient Employer _____ **Phone** _____

Address _____

Referring Provider _____

Is Your Condition / Injury a Result of: **Date of Injury** _____

Work Related Accident Yes _____ **No** _____

Auto Accident Yes _____ **No** _____

Other Accident Yes _____ **No** _____

Briefly Explain Other _____

How did you hear about our practice? _____

If Patient is a Minor, Responsible Party Information (Guarantor):

Name _____ **Date of Birth** _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

I understand and agree that, (regardless of insurance status), I am responsible for the balance of my account for any professional care rendered. I consent to the therapy / treatment which I am to receive or, in the case of a minor, which my child will receive. I have read and completed the above information regarding my case to insurance companies for the purpose of payment on my account.

Signature of Patient _____ **Date** _____

Signature of Guarantor (if minor) _____ **Date** _____

INSURANCE INFORMATION

Please give your insurance card to the receptionist.
We will need to make a copy for our records.

Primary Insurance _____

Subscriber ID# _____ **Group #** _____

Subscriber Name _____ **DOB** _____

Secondary Insurance _____

Subscriber ID# _____ **Group #** _____

Subscriber Name _____ **DOB** _____

FILL OUT THE FOLLOWING SECTION
ONLY IF THIS IS A WORKER'S COMPENSATION CLAIM

Worker's Compensation Carrier _____

Address _____

Carrier's Phone # _____

Adjuster's Name _____

Name of Employer _____

Address _____

Employer's Phone # _____

Date of Injury _____ **Claim #** _____

Assignment of Benefits

I authorize my insurance company, HMO, employer, or Medicare to pay Combined Therapy Specialties of Asheville, Inc. benefits payable under my policy as payment toward the charges for professional services rendered. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient / Guardian Signature **Date**

SPECIALTIES INFORMATION RELEASE

I _____ give my consent for any information regarding my care and treatment by Combined Therapy Specialties to be released to:

Name _____

Relationship _____

Date of Birth _____

Patient Signature _____

Have you been seen somewhere else for therapy in 2025? **Yes _____ No _____**

Are you receiving home health at the time? **Yes _____ No _____**

Are you currently a patient in an assisted living facility or skilled nursing facility? **Yes _____ No _____**

PRIVACY PRACTICE POLICY ACKNOWLEDGEMENT

I have been made aware of the Notice of Privacy Practices from Combined Therapy Specialties of Asheville and I have been provided with an opportunity to review it.

_____ _____

Patient / Guardian Signature **Date**

MESSAGING CONSENT

Regarding text messages or emails concerning
Appointments Combined Therapy Specialties of Asheville

Patients of our practice, Combined Therapy Specialties, may be contacted as a reminder of upcoming appointments or missed appointments.

The following disclosure and consent is for the purpose of obtaining permission to be contacted regarding appointments either by cell phone text messaging or by email.

I _____ give my consent to receive messages via text messaging or email as appointment reminders or reminders of missed appointments.

_____ I prefer to receive appointment reminders by cell phone text messaging.

Cell Phone # _____

_____ I prefer to receive appointment reminders by email.

Email Address _____

_____ I would like to opt in to receive the monthly newsletter. Initial _____

Email Address _____

I consent to receive calls/emails from Combined Therapy Specialties regarding my healthcare and other services including appointment reminders that such communications may be generated by an automatic dialing system. I am also aware that I may revoke this permission at any time through verbal or written notice. I understand that my authorization is optional and is not required in order to receive treatment by Combined Therapy Specialties.

_____ _____

Patient Signature **Date**