PATIENT INFORMATION FORM

First Name: ________________________ M.I.:____ Last Name: ______________________________DOB:_____________

Address: ____________________________________City: __________________State:________________ Zip: ____________

Phone (Cell or Home):_____________________Email:__________________________ SS#:_________________ Sex: ( ) M ( ) F

By providing a cell number, patient agrees to its use for calling and texting reminders.
( ) Check box if patient prefers to opt out of reminders by voicemail or text.

Emergency Contact____ Phone: ______________________________________

Employer: ____ Work Phone: _____________________ Ext:______

Work Address:____ Contact Name:________________________________

Location of Pain: ____

Cause of Pain: ( ) Auto Collision State: _______ ( ) Work Injury ( ) Slip & Fall ( ) Pedestrian MVA ( ) Other

Date of Incident: ____________________ Did you go to hospital: ( ) yes ( ) no If yes where?______________________

X-Rays Taken: ( ) Yes ( ) No Previous MVA's: ( ) Yes ( ) No If yes, when? __________________________________

Was MVA during work hours? ( ) Yes ( ) No Was incident reported to employer? ( ) Yes ( ) No Transportation Needed: ( )Yes ( ) No

AUTO/WORK INSURANCE INFORMATION

Insurance Name: ____________________________________ PCP Name: ____________________________________

Policy Holder's Name: _______________________________Date of Birth: ____

Policy Holder's Address: ____

Claim Number : __________________________________ Adjuster: ____

Adjuster's Phone Number: ____________________________Extension: ____

Household Insurance:________________________________ Insured Name: _______________________________________

HEALTH INSURANCE INFORMATION

Insurance Name:___________________________________ Policy Holders Name:_______________________ DOB:________

PCP Name:____ PCP Phone: ____

ID#:____ Group #:____

I understand that health and insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all money will be credited to my account upon receipt. I state that all the above information is true and accurate.

Patient Signature: ____ Date: ________________________

Caterra Health Systems

Name: ____________________________________ Date:_______________________

Circle Yes or No

	Self		***Family***	
Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Heart Attack	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No
High Blood Cholesterol	Yes	No	Yes	No
Smoking	Yes	No	Yes	No
Chest Pains	Yes	No	Yes	No
Dizziness/Fainting	Yes	No	Yes	No
Shortness of Breath	Yes	No	Yes	No
Ankle Swelling	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No
Rheumatoid Arthritis	Yes	No	Yes	No
Allergies	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Always have inhaler with you?	Yes	No	Yes	No
Seizures	Yes	No	Yes	No
Pacemaker/Defibrillator	Yes	No	Yes	No
Assistive Device (e.g. cane)	Yes	No	Yes	No
Unexplained weight change	Yes	No	Yes	No
Night Sweats	Yes	No	Yes	No
Numbness or tingling	Yes	No	Yes	No
Change in bowl/bladder	Yes	No	Yes	No

Are you or could you be pregnant? Yes No

Do you have a problem with (circle all that apply)

Hearing Speech

Vision Communication

Do you exercise? Yes No

Number of days per week? _________________

Number of Minutes per session? ______________

Your weight? ________ Your height? _______

Please list all medications you are currently taking?

(dosage not necessary)

____

____

____

____

List any medicine allergies that you have:

____

____

(PLEASE circle)Do you have or have had: MRSA, HIV/AIDS, Hepatitis A, Hepatitis B, Hepatitis C?

List any major surgeries you have had in the past:

____

____

____

Patient signature:

____

Caterra Health Systems

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct any treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians.
- Obtain outcome measures for research purposes.

I have been informed by you of your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***Notice of Privacy Practices*** prior to signing this consent. I understand that this organization has the *right* to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request *in writing* that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand you are *not required* to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent *in writing* at *any time*, *except* to the extent that you have taken action relying on this consent.

Patient Name: ______________________________ Date:______________________

Signature: ____

Relationship(s): ____

AUTHORIZATION

Authorization to Release Information: By signing this authorization you are deemed to understand and permit Caterra Health Systems, LLC, or any of its affiliates to release any information stated herein and any private or HIPPA protected information any of the aforesaid entities deem necessary to a third party investigator in the event that one is retained to contact you and/or to your attorney.

Medicare: I hereby request that payment of authorized medical benefits be made to Caterra Health Systems, LLC for any services furnished to me by any of those medical facilities. I authorize the release of any medical information about me, from any holder of said information, to the Health Care Financing Administration and its agents. That release encompasses any information needed to determine benefits payable for related services provided by Caterra Health Systems, LLC.

Commercial Insurance: I hereby authorize Caterra Health Systems, LLC, to submit claims to my insurance carrier or its intermediaries for any and all covered services rendered by Caterra Health Systems, LLC **DIRECT MY INSRUANCE CARRIER AND ITS INTERMEDIARIES TO ISSUE PAYMENT BY CHECK DIRECTLY TO THE CHARGING FACILITY.**

Pursuing Basic Reparation Benefits: I hereby authorize Caterra Health Systems, LLC, or any of its affiliates, to pursue any and all basic reparation benefits I am entitled to pursuant to KRS 304.39-030, *et. seq*.

Filing an Insurance Consumer Complaint: I hereby authorize Caterra Health Systems, LLC, LLC, or any of its affiliates, to file a Consumer Complaint against the insurance company providing my no-fault benefits with the Kentucky Department of Insurance for non-payment and/or delayed payment of any medical bills I incur.

Authorization to Release PIP Log: I hereby authorize Caterra Health Systems, LLC, or any of its affiliates to obtain my PIP log showing all payments made by my reparation obligor under KRS 304.29.

I understand that I am wholly financially responsible for any balance not covered by my insurance carrier(s).

Patient Name: ____________________________________

Signature: ____ Date: ______________________

PAYMENT AGREEMENT AND LIEN AUTHORIZATION

I, ______________________________________, do hereby authorize Caterra Health Systems, LLC to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, and complete patient file, in regards to the incident which forms the basis and need for my medical treatment with Caterra Health Systems, LLC.

I hereby authorize and direct you, my attorney, to pay directly to such sums as may be due and owing, Caterra Health Systems, LLC for medical services rendered to me by reasons of the aforesaid incident and/or for any medical treatment and services provided to me by Caterra Health Systems, LLC. I authorize you to withhold such sums from any settlement, judgment, and/or verdict as may be necessary to satisfy any outstanding amount owed to Caterra Health Systems, LLC for my medical treatment and care with its facility. I hereby further authorize a lien on my case to Caterra Health Systems, LLC LLC against any and all proceeds of any settlement, judgment, and/or verdict in which may be obtained by you, my attorney, on my behalf which in any way relates to the injuries for which I have been treated at the above named facility or in connection therewith.

I fully understand and agree that I am directly and wholly responsible to Caterra Health Systems, LLC for all medical bills submitted for services rendered to me and that this agreement is binding and made solely with Caterra Health Systems, LLC for additional protection and consideration of their awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment, and/or verdict by which I may eventually recover said fee and that my obligation for payment to Caterra Health Systems, LLC is continuing until any outstanding charges owed Caterra Health Systems, LLC are satisfied in full.

Patient Signature: ____________________________ Date: _________________________

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all the terms of the above agreement and further agrees to withhold such sums from any settlement, judgment, and/or verdict as may be necessary to satisfy any outstanding payment obligation of the above patient to Caterra Health Systems, LLC.

Attorney Signature: __________________________ Date: _________________________

Caterra Health Systems

DIRECTION OF PIP BENEFITS

I ____, hereby request, in writing, that payment be made directly to Caterra Health Systems, LLC, pursuant to KRS 304.39-241. Please provide immediate payment to both aforementioned entities pursuant to KRS 304.39-241, upon your receipt of each individual bill and expense as it is incurred. I understand that I have the right to direct payment pursuant to KRS 304.39-241, and affirm that this writing is to serve as my request to direct payment of my PIP benefits to Caterra Health Systems, LLC

Any provision of this writing which is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating the remaining portions hereof or affecting the validity or enforceability of such provision in any other jurisdiction.

This writing constitutes the entire and exclusive understanding and intent of the undersigned with respect to the subject matter hereof and supersedes and cancels all previous registrations, agreements, commitments, writings, and writings in respect thereof. This writing also acts to supersede and cancel all previous requests to direct payment of PIP benefits pursuant to KRS 304.39-241.

This Agreement shall be construed in accordance with the laws of the Commonwealth of Kentucky.

Patient Signature: ________________________ Date: ____________________

NOTICE TO PATIENTS: REASONS FOR DISCHARGE

Patient Name: _______________________ Date: __________________________

_____ I understand that it is Caterra Health Systems, LLC, policy to abide by the wishes of the patient when they state to Caterra Health Systems, LLC or any of Caterra Health Systems, LLC employees, contractors, agents or assigns, that they no longer want/need Caterra Health Systems, LLC services and wish to find a new physician or treating facility.

_____ I understand that it is Caterra Health Systems, LLC policy to refuse treatment for those patients that choose to disregard instructions or fail to follow up when orders are written for x-ray, MRI, diagnostic testing, medical treatment, physical rehabilitation, trigger point injections, epidural injections, etc.

_____ I understand that it is Caterra Health Systems, LLC policy to refuse treatment for any patient who verbally abuse any of the employees, contractors, agents or assigns of Caterra Health Systems, LLC.

_____ I understand it is Caterra Health Systems, LLC policy to dismiss patients or discontinue prescribing narcotic medication if any patient seeks narcotic medication from other sources and/or other physicians.

_____ I understand it is Caterra Health Systems, LLC policy, once all medical services are complete, to discharge said patient from Caterra Health Systems, LLC care. Caterra Health Systems, LLC will refer patients to other services if deemed needed and/or medically necessary for treatment. Caterra Health Systems, LLC does not provide primary family care services.

_____ I understand it is Caterra Health Systems, LLC policy to dismiss patients who repeatedly miss their scheduled appointments with therapy or physician visits.

_____ I understand that it is ***VERY*** important to contact Caterra Health Systems, LLC to reschedule missed appointments. Caterra Health Systems, LLC will be happy to adjust your schedule based on need.

_____ I understand that if I do not attend physical therapy or miss three (3) consecutive appointments, I am subject to discharge. Once I have been discharged, I understand that I will need a new physician's order/referral for any further therapy and will need a new physical therapy evaluation. This is in compliance with Kentucky law.

_________________________________ _______________________________

Patient Signature Physician Signature

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM DESIGNATED RECORD SET PURSUANT TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AND FEDERAL REGULATION 45 CFR 164.508

Patient's Name: ____

Address: ____

Date of Birth: ______________________ Social Security No.:__________________________

Pursuant to HIPAA and 45 CFR 164.508, I, _____________________________, hereby Authorize and Request Caterra Health Systems, LLC, Barrett & Associates Medical, PLLC, and Compass Medical Supply, LLC, and its Agents, Employees and/or Sub-Contractors to disclose the following specific Protected Health Information from my Designed Record sent to my attorney designated below, and his/her Agents, Employees and/or Sub-Contractors.

DESCRIPTION OF INFORMATION TO BE DISCLOSED

I hereby Authorize and Request the following specific Protected Health Information be disclosed to my attorney, ___________________________, and his/her Agents, Employees and/or Sub-contractors for all dates of service throughout the entirety of my treatment at Caterra Health Systems, LLC.

___ ALL RECORDS AND BILLS

PURPOSE OF REQUESTED USE

This Authorization is made "at the request of the individual." Pursuant to 45 CFR 164.508 (6)(c)(iv), this statement satisfied the "description of each purpose" requirement.

EXPIRATION OF AUTHORIZATION

This Authorization will expire on the date that you receive notice that my attorney no longer represents me, or One Hundred Eighty (180) days from today's date of ______________________, or whichever is sooner.

HIPAA NOTICE REQUIREMENTS

I understand that I have the right to revoke this Authorization in writing, except to the extent the Healthcare Provider has already taken action on it. I also understand that my medical treatment, payments, health insurance payments may not be conditioned on me signing this Authorization. I further understand that once my medical information and medical records are disclosed to my attorney and/or legal counsel, it may be subject to re-disclosure by said attorney or counsel, and will not be protected pursuant to the same privacy regulations.

______________________________	______________________________	____________________
WITNESS	PATIENT	DATE