WELCOME!

Welcome to Caddoo Rehabilitation Associates. We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we take very seriously. Here is some information that we hope will help answer any questions you may have.

Your commitment to your chiropractic or physical therapy program is critical to your success. We will recommend a treatment plan of care and set goals for you. In order to reach those goals you must do your part and **your most important part is to make each and every appointment.**

We will schedule and provide you with your appointment times to keep track of as well as give you a reminder when you check out. If you misplace your appointment times please give us a call to review your appointment dates. We will email reminders to you also.

While we expect you to keep all your appointments, we recognize there may be a time when you need to cancel. We require 24-hour notice if you need to cancel so we can fill your appointment time. If you do not give 24 hour notice or no show for an appointment, a $30.00 fee will be billed to you. Our number is (781) 894-8880.

Our staff will provide you with as much information regarding your insurance coverage as possible. We will contact your insurance company to verify your benefits and let you know what your responsibility is and what is due at time of service. We encourage you to call your insurance carrier to discuss your coverage and what your financial obligations may be as we sometimes are given wrong information.

Our Front Desk Specialists are here if you have any questions regarding your appointments, insurance, financial responsibilities, scheduling or any other issues. Please speak with your therapist if you have any questions regarding your therapy treatment.

We thank you for choosing Caddoo Rehabilitation Associates and we look forward to providing you with exceptional customer service and helping you reach your goals.

The Staff at Caddoo Rehabilitation Associates

I have read and understand the above information:

____________________________________ ______________________________
Patient/Guardian Date

Caddoo Rehabilitation
Associates
CHIROPRACTIC & PHYSICAL THERAPY

Patient Information

Today's Date	☐ Auto ☐ Worker's Comp ☐ Other	Area to be Treated	
Last Name		First Name, Middle Initial	
Street Address	City/Town	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Date of Birth	Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced	

Appointment Reminders: ☐

Email:

Emergency Contact Name:	Phone	Relationship to Patient
Primary Care Physician Name	Phone #	Have You Had Physical Therapy Before? ☐ Yes ☐ No
Referring Physician Name	Phone #	If yes, when:

Primary Health Insurance Carrier	Member ID#	Group #
Subscriber's Name	Subscriber's Date of Birth	Relationship to Patient
Address (if different from patient)		Subscriber's Phone #
Secondary Health Insurance Carrier (if applicable)	Member ID#	Group #

Are you currently, or have you recently had home health services? ☐ Yes ☐ No	If yes, are you still receiving service? ☐ Yes ☐ No
	If not, when were you discharged?

Have you received physical therapy/chiropractic treatment for your current or any other condition within the last 12 months? ☐ Yes ☐ No

If yes, when ____

How did you hear about us?

Please fill out back side →

CONSENT TO TREATMENT

I hereby authorize the professional staff at Patient First Chiropractic and Physical Therapy dba Caddoo Rehabilitation Associates to examine and treat me with chiropractic/physical therapy for the injury I have been referred here for or referred myself to.

______________________________ Patient Signature	______________________________ Date
______________________________ Patient Printed Name	______________________________ Staff Witness Signature
______________________________ Parent or Guardian Signature (if under 18)	______________________________ Date
______________________________ Parent or Guardian Printed Name	______________________________ Staff Witness Signature

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) ____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: Patient First Chiropractic and Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

______________________________ Patient Signature	______________________________ Date
______________________________ Patient Printed Name	______________________________ Staff Witness Signature
______________________________ Parent or Guardian Signature (if under 18)	______________________________ Date
______________________________ Parent or Guardian Printed Name	______________________________ Staff Witness Signature

HIPAA REGULATIONS

I understand that Patient First Chiropractic and Physical Therapy dba Caddoo Rehabilitation Associates complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

I have received a copy of the Notice of Information Practices. A photocopy of this Assignment shall be considered effective and valid as the original.

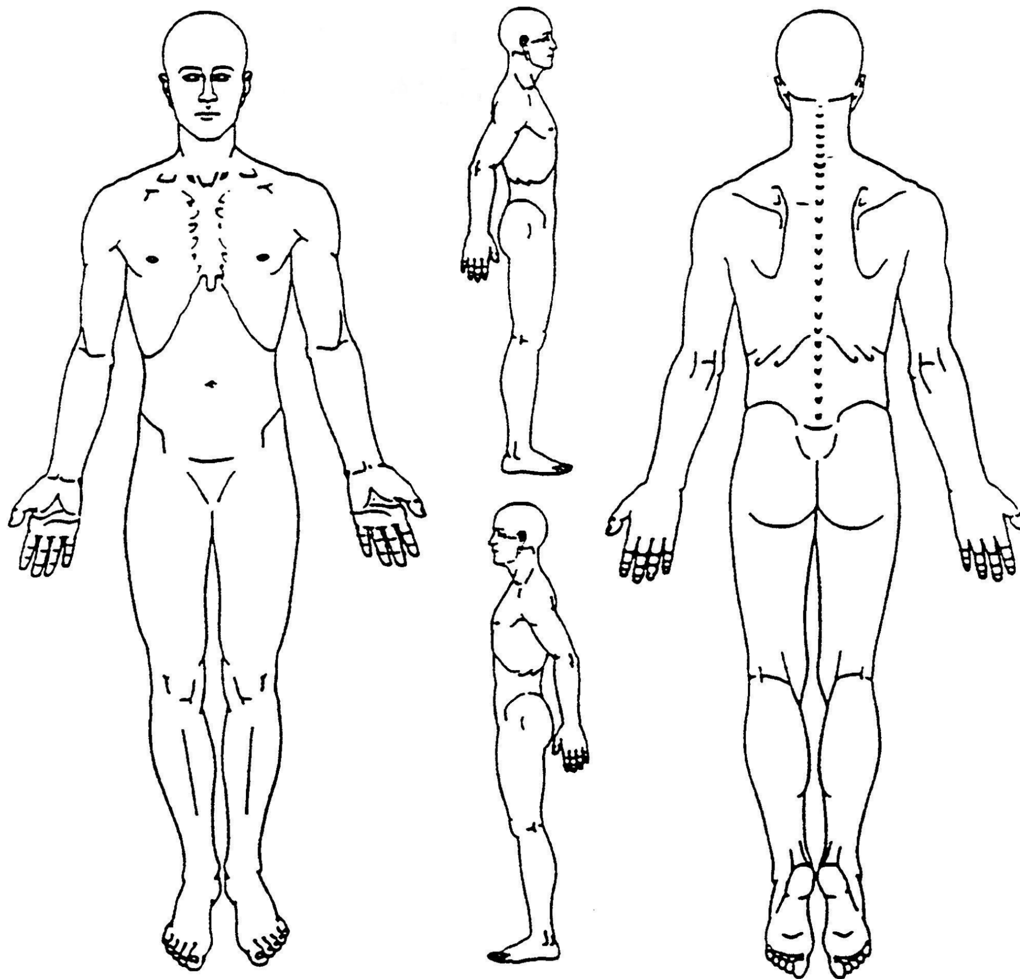
______________________________ Patient Signature	______________________________ Date
______________________________ Patient Printed Name	______________________________ Staff Witness Signature
______________________________ Parent or Guardian Signature (if under 18)	______________________________ Date
______________________________ Parent or Guardian Printed Name	______________________________ Staff Witness Signature

Name: ____ Date: ________________________

Body Diagram

Instructions: On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.

Key: A = Ache B = Burning N = Numbness S = Stabbing P = Pins and Needles O = Other



Circle your current level of pain on the line below.