Community cTx TherapeutiX
ctxcares.com
Office: 860-848-4180 | Fax: 860-574-9393 • 601B Broad Street | New London, CT 06320

Patient Name:_____DOB:_____

Address:_____
Street City/State Zip Code

Mailing Address:_____
Street City/State Zip Code

Home Phone:_____Cell:_____Work:_____

Sex: Male/Female Marital Status: S M D W Email: _____

Employer:_____
Name Address Phone

Person to Notify In Case of Emergency_____
Name Relationship

_____
Phone Address

~~~~~~

Person Responsible for Bill if Patient is a Minor:

Guarantor Name:_____ DOB:_____

Address:_____

Phone:_____ SSN:_____ Relationship to patient:_____

Employer:_____
Name Address Phone

~~~~~~

Health Insurance Information—Please provide the office with a current copy of insurance card(s)

Primary Ins:_____ID#_____Group #_____

Policy Holder:_____
Name Address Phone

_____
DOB SSN Employer Relationship to Patient

Secondary Ins:_____ID#_____Group #_____

Policy Holder:_____
Name Address Phone

_____
DOB SSN Employer Relationship to Patient

Tertiary Ins:_____ID#_____Group #_____

Policy Holder:_____
Name Address Phone

_____DOB
SSN Employer Relationship to Patient

_____ _____
Signature of person completing form Today's date

Community CTX TherapeutiX
ctxcares.com
Office: 860-848-4180 | Fax: 860-574-9393 • 601B Broad Street | New London, CT 06320

Patient Consent and Authorization
Acknowledgement of Receipt of Notice of Privacy Practices
Acknowledgement of Receipt of Cancellation/No-Show Policy

*I hereby authorize Community Therapeutix (CTX) personnel and contracted staff to perform any and all tests or procedures relative to my care, injury/illness and/or physical examination as deemed necessary and advisable by the provider and/or employer.
*I hereby give permission to my third-party payer (Insurance carrier, PPO, HMO, employer) to directly pay CTX for services rendered to me. I understand I am responsible for any applicable balance remaining after my insurance has paid and I am to pay the difference within 30 days of notification by CTX or my insurance company.
*I have been made aware that if the physician does not participate with my health insurance plan, I will be responsible for any applicable charges.
*I understand and accept that I must pay for any charges which I am billed by CTX. I understand that if these medical bills are not paid on time, they may be turned over to a collection agency. If this happens, I understand that I will have to pay, and I agree to pay reasonable collection and attorney fees in addition to lawful interest and cost.
*This office participates with an electronic medical record.
*This authorization will remain in effect until revoked in by me in writing except to the extent that the practice already made disclosures in reliance upon my prior consent.
*I hereby acknowledge I have received a copy of the Notice of Privacy Practices. I understand if I have any further questions or complaints I may contact: CTX at 860-848-4180.
*I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy Practices is amended or changed in a material way.
*I hereby acknowledge I have received a copy of the Cancellation/No-Show Policy and understand my responsibilities regarding this policy.
*My signature below indicates that I have read and understand each of the paragraphs above.

_____ _____
Date Patient Signature or Legally Authorized Representative*

*If Legally Authorized Representative: Relationship to Patient: _____

_____ _____
Date Staff Signature