Patient Intake Form

ARIZONA ORTHOPEDIC PHYSICAL THERAPY
Feel better. Function better. Live better.

Patient Information

Name: ____ Gender: Male Female

Address: ______________________________________ Date of Birth: ___________________

City: ______________________________ State: _______ Zip: __________

Social Security Number: ___________________ Marital Status: ____________________________

Home Phone: __________________________ Work Phone: _____________________________

Mobile/Pager Phone: ____________________ E-mail: __________________________________

Referring Physician: _____________________ Primary Physician: _________________________

Employment Status: ______________________ Occupation: _____________________________

Employers Name: ________________________ Employers Phone: _________________________

Emergency Contacts

1. Name: __________________________Relationship: _________________ Phone: _____________

2. Name: __________________________Relationship: _________________ Phone: _____________

Please tell us who your other providers are: and, may we have permission to contact them: Y N

Cardiologist: ____________________________________ Phone: _________________________

OBGYN: ____ Phone: _________________________

Dentist: ____ Phone: _________________________

Other: ____ Phone: _________________________

Primary Insurance Information

Insurance Company Name: ____

Type of Insurance:___________________________ ID#: _______________________________

Subscribers Name: __________________________ Group/Policy Number: __________________

Relationship to Patient:________________________ Subscribers Employer: __________________

Subscribers SSN: ___________________________ Subscribers DOB: ______________________

Customer Service Phone Number (Located on back of insurance card): ______________________________

Secondary Insurance Information

Insurance Company Name: ____

Type of Insurance:___________________________ ID#: _______________________________

Subscribers Name: __________________________ Group/Policy Number: __________________

Relationship to Patient:________________________ Subscribers Employer: __________________

Subscribers SSN: ___________________________ Subscribers DOB: ______________________

Customer Service Phone Number (Located on back of insurance card): ______________________________

If your injury is related to work or an auto accident, please provide our office with the details of your insurance coverage for this incident.

Patient History

ARIZONA ORTHOPEDIC PHYSICAL THERAPY
Feel better. Function better. Live better.

Patient Name: ____ DOB: ______________________________

General Instructions: Indicate Yes or No for each item below. If Yes, indicate your age when it occurred.

Yes/No Age		Yes/No Age		Yes/No Age	
_______	Arthritis/Rheumatism	________	Asthma/Wheezing	________	Emotional Problems
_______	Broken Bones	________	Pneumonia/Pleurisy	________	Alcohol/Drug Addictions
_______	Dislocated Joints	________	Tuberculosis	________	Neuritis/Pinched Nerves
_______	Painful/Stiff Joints	________	Chronic Cough	________	Polio or Paralysis
_______	Elbow/Shoulder Trouble	________	Phlegm or Spitting Blood	________	Kidney Disease or Stones
_______	Knee Trouble	________	Breathing Difficulties	________	Blood Disease or Anemia
_______	Foot Trouble	________	Swelling of Ankles	________	Cancer, Tumor or Growths
_______	Head, Neck or Spinal Injuries	________	Chest Pain or Pressure	________	Jaundice or Hepatitis
_______	Back Trouble	________	Rheumatic or Scarlet Fever	________	Stomach Trouble or Ulcer
_______	Eye Trouble or Injury	________	Heart Trouble or Murmur	________	Hemorrhoids or Rectal Disease
_______	Hay Fever or Allergy	________	High Blood Pressure	________	Hernia (Rupture)
_______	Hives, Eczema or Skin Trouble	________	Epilepsy, Fits or Convulsions	________	Diabetes
_______	Sinus Trouble	________	Frequent or Severe Headaches	________	Varicose Veins
_______	Chronic Ear Infections	________	Dizziness or Fainting	________	Hearing Difficulty

General Instructions: Check Yes or No column for the following items. If Yes, please explain.

Yes	No	
____	____	Have you ever had any serious ill effects from activities you have done? ____________________
____	____	Has your activity ever had to be limited or restricted on account of your health? ____________________
____	____	Have you ever been a patient in a hospital? ____________________
____	____	Do you have any condition, which may require limits to your daily activities? ____________________
____	____	Have you ever had any surgical operation, or been advised to have one? ____________________
____	____	Have you ever had an injury or ailment to your neck and/or back? ____________________
____	____	Have you ever had an injury or operation to either knee or shoulder? ____________________

Do you now (as of 1 month ago) smoke cigarettes? YES _____ NO ______

How many years have you smoked (did smoke) cigarettes? ___________________

Are you taking medication? Please list. ____

WOMEN: Are you pregnant? YES _____ NO ______

I, ______________________________, (DOB______________) hereby request and consent to the performance of therapy, including examination and diagnosis, on me by Arizona Orthopedic Physical Therapy, PLLC and other physical therapists and occupational therapists under Arizona Orthopedic Physical Therapy, PLLC supervision. I consent to the treatment plan and intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature ____ Date ___________________________

Physical Therapist Signature (Reviewed by)____

ARIZONA ORTHOPEDIC PHYSICAL THERAPY
Feel better. Function better. Live better.

Financial Policy

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

We will request a photocopy of the front and back of your insurance identification card and driver's license. Please update your card with any additional information your insurance company provides, which will facilitate the submission of claims on your behalf. It is your responsibility to inform us of any changes to your policy. We will bill your insurance company on your behalf as a courtesy.

Co-Payments: We must collect your carrier-designated co-pay at the time of service. Refusal to abide by this agreement may result in termination of your coverage.

Missed Appointments: Patients who do not show up for an appointment, and do not call to cancel have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patients' insurance contract, we reserve the right to charge a $20.00 fee for missed appointments.

Bounced Checks: If a check is used as your form of payment, and that check is returned for insufficient funds or payment has been stopped, you will be charged a $25.00 fee in addition to the amount of the check.

Insurance

We will gladly bill and accept payment from your health insurance plan. Your co-payment or deductible is due and payable at the time of service. We accept cash, checks, Mastercard and Visa. Any amounts not covered by your insurance carrier are your responsibility.

Payments

You are responsible for any amount not covered by your insurance carrier. All co-payments and deductible amounts are due at the time of service.

We find communication between our office and our patients help us to succeed in providing the best care. Please advise us if your insurance company has pre-certification and/or prior authorization requirements and/or policy restrictions and limitations.

Patient or Guarantor

I have read and understand the above. I hereby authorize Arizona Orthopedic Physical Therapy, PLLC to submit claims to my insurance carrier. I hereby authorize direct payment of benefits, otherwise payable to me, to be made payable to Arizona Orthopedic Physical Therapy, PLLC. I understand I will be responsible for payment of any amounts not covered by my insurance carrier, including, but not limited to, co-payments and deductibles.

Signed: ______________________________ Date: ____________________

Authorization for the Release of Medical Records

I hereby authorize Arizona Orthopedic Physical Therapy, PLLC to release the medical record(s) of:

Patient's Name: ____

Date of Birth: ____

for the purpose of continued treatment and billing/re-assignment of benefits (allows AZ-OPT to bill on your behalf, and for the payment to be sent directly to AZ-OPT) to:

Arizona Orthopedic Physical Therapy, PLLC.
14535 W. Indian School Rd.
Suite 100
Goodyear, AZ 85338
Phone: 623-242-6908
Fax: 623-242-2909

Signature of Patient or Patient's Personal Representative: _________________________________

Date: _________________________________

Printed Name of Personal Representative (if any): _______________________________________

Representative's Authority to Act for Patient: ____

Notice of Privacy Practices

Your name and signature on this cover sheet indicate that you have received a copy of and/or have been directed to the poster displayed in the clinic lobby of Arizona Orthopedic Physical Therapy, PLLC (AZ-OPT's) Notice of Privacy Practices on the date and time indicated. If you have any questions regarding the information set forth in AZ-OPT's Notice of Privacy Practices, please do not hesitate to ask at the desk or the physical therapist.

Name: ____

Signature: ____

Date and Time Notice Received: _______________________________________