New Patient Information

Please print legibly:

Patient Name:_____ Gender: ☐ Male ☐ Female

Diagnosis: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Parent(s)/Guardian(s): _____

Primary Physician: _____ PP Phone: _____

Referring Physician: _____ RP Phone: _____

Support Coordinator (if applicable): _____ SC Phone: _____

How did you hear about Kids Place? _____

Kids Place prefers to keep its business "in the family" when possible. Are you involved in a business that could develop a relationship with Kids Place (i.e. graphic design, office supplies, printing, construction, etc.)?

_____

_____

Emergency Contacts

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Primary Insurance Information

Insurance Company Name: _____

Subscribers Name: _____ Subscribers DOB: _____

ID#: _____ Group/Policy Number: _____

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

Secondary Insurance Information

Insurance Company Name: _____

Subscribers Name: _____ Subscribers DOB: _____

ID#: _____ Group/Policy Number: _____

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

Developmental History

Patient Name: _____ DOB: _____

Reason for Referral: _____

Diagnoses: _____

Parent/Caregiver Primary Concern (s): _____

Birth History

Weight: _____ Length: _____

Was your child born prematurely? ☐ Yes ☐ No If yes, what week was your child born? _____

Delivery

☐ Spontaneous
☐ Induced
☐ Breech
☐ Normal
☐ Cesarean
☐ Cord around neck
☐ Hemorrhage
☐ Infant Injured during delivery

Please explain: _____

☐ Positive for substances

Please explain: _____

Post Delivery Period *(please complete only if there were delivery complications)*

☐ Jaundice
☐ Intensive Care
☐ Cerebral Bleed
☐ Cyanosis (turned blue)
☐ Infection: _____
☐ Other Complications: _____

Number of days in the hospital after delivery for the child: _____

Early Development *(please list all relevant milestones)*

Sitting Unsupported: _____ Crawling: _____

Walking: _____ First Word: _____

Toilet Trained: _____ Dress Self: _____

Please list all relevant surgeries: _____

_____

Background

Previous therapies (please check all that apply): ☐ PT ☐ OT ☐ SPEECH ☐ FEEDING ☐ VISION

Is your child receiving therapy services in school? YES ☐ NO ☐

If yes, what services? _____ If yes, what school? _____

Medications

Please list any and all medications that your child is currently taking: _____

_____

Financial Policies

Please initial each section and sign below:

AZOPT Kids Place is committed to providing the best possible care, and therefore, your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, financial policy, or your financial responsibility.

AZOPT Kids Place 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.

_____
Initial

Co-Payment/Co-Insurance

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.

AZOPT Kids Place will calculate an estimated co-payment or co-insurance based on your insurance policy. This amount will be due at the time of each appointment.

_____
Initial

Missed Appointments

Patients who do not show up for an appointment, or call to cancel with less than 24 hours' notice 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 $50.00 fee for no-show or same day cancelled appointments.**

_____
Initial

Returned Checks

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

_____
Initial

Insurance

We will gladly bill and accept payment from your health insurance plan. Any amounts not covered by your insurance carrier are your responsibility.

Communication between AZOPT Kids Place and our patients help us 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.

_____
Initial

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. For your convenience, we do accept all major credit cards, checks, money orders, and cash.

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: _____

Patient Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to providing you with the highest quality of care. The following is a statement of our financial policy, which we require you read and agree to sign prior to any treatment.

Patient Financial Responsibilities

- It is my responsibility to know my own insurance benefits, including whether AzOPT is a contracted provider with my insurance company, my covered benefits, and any exclusions in my insurance policy, and any pre-authorization requirements of my insurance company.
- AzOPT will attempt to confirm my insurance coverage prior to my treatment. It is my responsibility to provide current and accurate insurance information, including any updates or changes in coverage. I am financially responsible should I not provide this information.
- Estimate charges may be given at or before the time of service, but I understand that this is merely an estimate, based on information available at this time. Actual amount I will be charged for services rendered may be different from the estimate of charges for a variety of reasons, including but not limited to, additional treatments, supplies, or services not covered in the estimate.
- AzOPT will bill my insurance company first, less any copayment(s) or deductible(s), and then bill me for any amount determined to be my responsibility, in accordance with my insurance policy. This process generally takes 45-60 days from the time the claim is received by the insurance company. A detailed Explanation of Benefits (EOB) is available from the insurance company when the claim is finalized.
- If my insurance contract contains a Coordination of Benefits (COB) provision, it is my responsibility to contact my insurance plan and update the necessary information. I am aware that if this is not done, I am responsible for any visits not paid by insurance.
- If I am uninsured, I agree to pay for the services rendered to me at the time of service. If I am unable to pay the totality of the medical services rendered at the time of service, I will make a payment plan or other payment arrangement with the clinic.
- Co-pays and/or deductible payments are due at the time of service.
- AzOPT will ask to make a copy of my ID and insurance cards for their records.
- AzOPT accepts any form of payment – cash, check, or credit card.
- In the event that a payment is missed, accounts need to be settled prior to the next appointment, or future scheduled appointments may be cancelled.

Patient or Guarantor

I have read and understand the above. 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: _____

Kids Place Policies

Please initial each section and sign below:

_____
Initial

Cancellation / No Show Policy

As a team we have created a plan of care for your child to meet his/her therapy needs. Following this plan of care, and attending scheduled sessions, is important in order to meet your child's full potential. If you do not abide by the plan of care, your child may be removed from their permanently scheduled appointment. The following are examples:

Your child misses two separate appointments without our office receiving a phone call.

Failure to call and cancel your appointment at least four hours before your scheduled time is considered a no-show. We have a voice mail that is checked early so you may call after hours or early in the morning.

Your child cancels three separate appointments within one quarter, without a hospitalization or a severe illness.

Please note: a rescheduled appointment within the same week is not a cancellation.

_____
Initial

Discharge Policy

Your child's therapy needs may change during the course of treatment. The following conditions may result in your therapist recommending discharge from Kids Place:

Plateau in function

Kids Place is committed to creating an environment that allows each child to grow. Goals are updated each quarter based on areas of need and concerns. After each quarter, progress towards these goals is discussed with caregivers, and new/updated goals are established. If a child has reached a plateau and has not made progress in 6 months, the child may be discharged.

Meeting all goals

When a child meets all of their established goals, and there are no further functional or objective goals to meet, a child will be discharged.

I, _____, (Patient Name:_____) have read and understand the above policies and hereby request and consent to the performance of therapy, including examination and diagnosis, of my child by Arizona Orthopedic Physical Therapy, PLLC. I consent to the treatment plan and intend this consent form to cover the entire course of treatment for my child's present condition and for any future conditions for which we seek treatment.

Patient/Guardian Signature _____ 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, this allows AZOPT to bill on your behalf, and for the payment to be sent directly to AZOPT, to:

Arizona Orthopedic Physical Therapy, PLLC
14557 W. Indian School Rd. #500
Goodyear, AZ 85395
Phone: 623-242-6908
Fax: 623-242-6909

Signature of Guardian: _____

Printed Name: _____ Date: _____

Notice of Privacy Practices

Your name and signature below indicate that you have received a copy of and/or have been directed to the Notice of Privacy Practices by Arizona Orthopedic Physical Therapy, PLLC, on the date indicated. If you have any questions regarding the information set forth in AZOPT's Notice of Privacy Practices, please do not hesitate to ask an AZOPT representative.

Signature of Guardian: _____

Printed Name: _____ Date: _____

Photo Consent Release

I would like to extend permission to Arizona Orthopedic Physical Therapy, PLLC (AZOPT) to use my:

- Name Yes ☐ No ☐
- Testimonial Yes ☐ No ☐
- Image/photograph Yes ☐ No ☐

in publications and advertisements produced by or for AZOPT. I understand that these publications will also be placed on web sites managed by AZOPT for public relations and advertising purposes. I understand that the publication may appear on the Internet, the publication may appear in print, electronic, or video media, and the publication may enable readers to identify me. I understand this consent is valid until I provide written notice stating otherwise.

Signature of Guardian: _____

Printed Name: _____ Date: _____