

New Patient Information

Please print legibly:

Patient Name: _____ Gender: Male Female

Patient Address: _____ Patient DOB: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Alternate Phone: _____

To receive messages related to appointment reminders, insurance and billing information via telephone, SMS text messaging, and/or email, please check here*
By checking the box above, I authorize Arizona Orthopedic Physical Therapy (AZOPT) to send me information about my appointments, appointment reminders, and insurance, account or billing items via email, SMS text message, or my preferred phone, or any other phone number that I provide to AzOPT. I also authorize AzOPT personnel to leave a voice mail with information related to my appointments, appointment reminders, insurance, account or billing items.

Email: _____

Parent/Guardian (if under 18): _____

Primary Physician: _____ PP Phone: _____

Referring Physician: _____ RP Phone: _____

How did you hear about AZOPT? _____

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

Emergency Contacts

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Primary Insurance Information

Is this injury related to a car accident? [Y] [N]

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): _____

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

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	_____ Eye Trouble or Injury
_____ Heart Trouble or Murmur	_____ High Blood Pressure	_____ Hernia (Rupture)
_____ Epilepsy, Fits or Convulsions	_____ Diabetes	_____ Frequent/Severe Headaches
_____ Dizziness or Fainting	_____ Hearing Difficulty	_____ HIV/AIDS

General Instructions: Check Yes or No in the appropriate 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?
_____	_____	Do you have any allergies or past allergic reactions?
_____	_____	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? _____

Please list any and all medications you are currently taking:

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/Guardian Signature _____ Date _____

Physical Therapist Signature (Reviewed by) _____

Financial Policies

Please initial each section and sign below:

AZOPT 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 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-Payment/Co-Insurance

Initial

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 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.

Missed Appointments

Initial

Patients who do not show up for an appointment, or call to cancel with less than 4 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 \$150.00 fee for no-show or same day cancelled evaluations and/or a \$75 fee for follow up appointments.**

Returned Checks

Initial

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.

Insurance

Initial

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 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.

Payments

Initial

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: _____

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 Patient/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 Patient/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 <input type="checkbox"/> | No <input type="checkbox"/> |
| • Testimonial | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Image/photograph | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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 Patient/Guardian: _____

Printed Name: _____ Date: _____