

Previous Patient? Y / N **Date:** _____
Last Name _____ **First Name** _____ **MI** _____
Street Address _____
City _____ **State** _____ **Zip** _____ **Ailment** _____
Telephone: Home (____) _____ - _____ **Cell** (____) _____ - _____
Work (____) _____ - _____ **E-Mail** _____
Would you like to receive appointment reminders by E-mail? Y / N
Date of Birth ____ / ____ / ____ **Social Security #** ____ - ____ - ____
Emergency Contact _____ **Phone** (____) _____ - _____
Referring Physician _____ **PCP** _____
How Did You Hear About Us? () Ad () sign () doctor () ins. Co. () website () friend _____
Appt time needed: _____ **Flexible?** Y / N
Insurance: () BC/BS () Medicare () Auto () WC () Other
Do you have secondary insurance? () Yes () No

EMPLOYER INFORMATION

Employer Name _____
Work Telephone (____) _____ - _____ **Job Title** _____
Street Address _____
City _____ **State** _____ **Zip** _____

RESPONSIBLE PARTY INFORMATION

Who is the Insured?: Self () Spouse () Parent () Other ()
Last Name _____ **First Name** _____ **MI** _____
Street Address _____
City _____ **State** _____ **Zip** _____
Home Telephone (____) _____ - _____ **Work Telephone** (____) _____ - _____
Date of Birth ____ / ____ / ____ **Social Security #** ____ - ____ - ____

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to *Arizona's Premier Physical Therapy*. I also acknowledge by signing below I hereby accept the terms and agreements made by the attached *Arizona's Premier Physical Therapy Patient Registration and Consent for Medical Treatment Form*.

_____ _____ _____
Patient/Responsible Party Signature **Relationship** **Date**

PATIENT NAME: _____

PRIMARY INSURANCE INFORMATION/VERIFICATION

() Workers Compensation () Auto/No Fault () Medicare () BC/BS () Commercial
() Other

Date of Injury _____ Was injury related to accident? () Yes () No

Insurance Company _____

Policy/Claim # _____ Group # _____

Case Manager _____

Insurance Billing Address _____

City _____ State _____ Zip Code _____

Telephone: (____) _____ - _____ Fax: (____) _____ - _____

Effective Date _____ Maximum # of Visits _____ / _____

PRECERT REQUIRED () Yes () No **REFERRAL REQUIRED** () Yes () No

% Coverage _____ Co-Pay _____ In Network _____ Out of Network _____

Deductible _____ Amount Met _____ Out of Pocket _____

Authorization # _____ Start Date _____ End Date _____

Comments _____

Spoke with _____ Date _____

SECONDARY INSURANCE INFORMATION/VERIFICATION

() Auto/No Fault () Medicare () BC/BS () Commercial () Other

Date of Injury _____ Was injury related to accident? () Yes () No

Insurance Company _____

Policy/Claim # _____ Group # _____

Case Manager _____

Insurance Billing Address _____

City _____ State _____ Zip Code _____

Telephone: (____) _____ - _____ Fax: (____) _____ - _____

Effective Date _____ Maximum # of Visits _____ / _____

PRECERT REQUIRED () Yes () No **REFERRAL REQUIRED** () Yes () No

% Coverage _____ Co-Pay _____ In Network _____ Out of Network _____

Deductible _____ Amount Met _____ Out of Pocket _____

Authorization # _____ Start Date _____ End Date _____

Comments _____

Spoke with _____ Date _____

Arizona's Premier Physical Therapy
Patient Registration and Consent for Medical Treatment

1. **Consent for Health Care Services:** I authorize consent for medical treatment at *Arizona's Premier Physical Therapy*.
2. **Authorization for Release or Information:** *Arizona's Premier Physical Therapy* may release information from my medical records to any health care provider involved in my care and treatment. *Arizona's Premier Physical Therapy* may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, *Arizona's Premier Physical Therapy* is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by *Arizona's Premier Physical Therapy* which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from *Arizona's Premier Physical Therapy*, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with *Arizona's Premier Physical Therapy*. I understand that I am responsible for a \$25.00 returned check fee in addition to any other associated bank charges.
4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorization's and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of *Arizona's Premier Physical Therapy* charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to *Arizona's Premier Physical Therapy* charges not paid.
6. **Charge for No Show/Cancellation without 24 hour notice:** I understand that 24 hour notice is required for canceling an appointment, and I will be charged a \$25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

I acknowledge that:

- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for the payment and/or co-payment that is due at the time of service.
- I have received a copy of *Arizona's Premier Physical Therapy*. HIPAA Policy

Signature of Patient or Legally Responsible Person

Name (PRINT)

Relationship/Reason Why Patient is Unable to Sign

Date

INSURANCE WAIVER

I understand that *Arizona's Premier Physical Therapy* is not an in-network participating provider for my insurance company. I agree to pay all charges and will submit on my own for reimbursement of any charges from my insurance company.

Signature of Patient or Legally Responsible Person

Name (PRINT)

Relationship/Reason Why Patient is Unable to Sign

Date