

INSURED/CASH PATIENT INFORMATION

Arizona Advanced Physical Therapy
4838 E. Baseline, #105, Mesa, Az 85206
Phone: 480.890.9000 Fax: 480.890.9100

PATIENT INFORMATION:

Name _____ Soc Sec # _____ Date of Birth _____
Age ____ Gender ____ Marital Status (circle one) Single Married Divorced Widowed
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Employer _____
Emergency Contact _____ Phone _____
Referring Physician _____ Phone _____
Primary Care Physician _____ Phone _____

INSURED PERSON'S INFORMATION:

Insured Name _____ Insured Soc Sec # _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Employer _____
Primary Insurance Company Name _____ Phone _____
Policy # _____ Group # _____
Secondary Insurance Info:
Company Name _____ Phone _____
Policy # _____ Group # _____
If injury is result of an accident:
Type of Accident: Auto Industrial Other _____ Date of Accident: _____
Do you have an attorney representing you? Yes No
If yes: Attorney Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Has your attorney signed a lien? Yes No

ASSIGNMENT OF BENEFITS:

I hereby give my consent for treatment. I hereby authorize my physical therapist and/or billing agent to release any medical or incidental information to process this claim for financial benefits. This assignment will remain in effect until revoked by me in writing. I hereby authorize payments of medical benefits be paid directly to *Arizona Advanced Physical Therapy* for services rendered. A photocopy of this assignment shall be considered as effective and valid as the original. Obligation: I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THESE SERVICES.

Signed (patient, insured or responsible party)

Date

Patient Name (please print) _____

MEDICAL HISTORY

- Primary reason for your visit today _____
- Is this the first time you have been treated for this condition? Yes No
- Have you been seen for physical therapy in the past? Yes No
When and why? _____
- List any medications you are taking _____

- Do you have any surgical implants? (e.g., breast, joint replacement, hardware, valve replacement)
 Yes No If yes, for how long? _____
- Is there anything that makes your condition feel worse? _____

- Is there anything that makes your condition feel better? _____

- Is there any possibility that you may be pregnant? Yes No

(If at any time during the course of treatment you think you may be pregnant, please let your therapist know as that may affect your treatment.)

- Do you, or have you ever had, any of the following:

	Yes	No	Comments
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery/Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____



ARIZONA ADVANCED PHYSICAL THERAPY

Training & experience backed by a hands-on approach

NOTICE OF PRIVACY PRACTICE

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information.

This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications: You can request that your practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain entities.

INITIALS



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OFFICE POLICIES

- **Hours /appointments are available**:**
 - Mondays from 7AM until 4:30PM
 - Tuesdays and Thursdays from 7AM until noon
 - Wednesdays and Fridays from 10AM until 4:30PM
- **Therapists:**
 - Greg Sonntag, PT**
 - Jessica Leitch, PT**
 - ** ALL HOURS AND SHIFTS ARE SUBJECT TO CHANGE**
- **Cancellation/No show:**
 - There will be a \$45.00 fee for any missed appointment without a 24 hour notice. This is not covered by insurance. If you cannot make your appointment, please call. We have an answering machine and we will get your message.
 - If you are more than 15 minutes late, you may be asked to reschedule.
- **Payment and Co-Pays:**
 - Payment and co-pays are due at the time of services unless other prior arrangements have been made. We **do** accept cash and checks. We **do not** accept credit cards.
- **Past Due Accounts:**
 - A fee will be added to all unpaid balances that require collection and/or legal services
- **Insurance:**
 - We **do not** accept *HMO's* or *EPO's*.
 - If your insurance changes, it is important to notify us and supply us with a copy of your new insurance card.
- **Referring physician appointments:**
 - Please notify us at least 48 hours prior to any appointment with your physician. We keep in close contact with your referring doctor regarding your care and need the 48 hour notice to have time to prepare a progress report for your doctor.
- **Miscellaneous:**
 - Some patients are very sensitive to strong odors. Please be considerate when applying perfume and/or cologne before your appointments.
- **Privacy Practices:**
 - I have been given a copy of Arizona Advanced Physical Therapy's privacy practices.
- _____ I have read Arizona Advanced Physical Therapy Office Policies, I understand them and agree to follow them.