

1MEDICARE 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 _____ Retirement Date _____
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:

Name _____ Soc Sec # _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Employer _____

SECONDARY INSURANCE INFORMATION:

Insured Name _____ Insured Soc Sec # _____
Insurance Company _____ Insurance Co Phone # _____
Policy # _____

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 _____

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	_____	_____	_____
Asthma	_____	_____	_____
Allergies	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Hypoglycemia	_____	_____	_____
Heart Attack	_____	_____	_____
Heart Condition	_____	_____	_____
Osteoporosis	_____	_____	_____
Thyroid	_____	_____	_____
Pacemaker	_____	_____	_____
Stroke	_____	_____	_____
Seizures	_____	_____	_____
Surgery/Other	_____	_____	_____
Vascular Disorder	_____	_____	_____

OFFICE POLICIES

☐ **Hours /appointments are available:** Mondays, Wednesdays and Fridays 9:30 am - 4:00 pm
Tuesdays and Thursdays 7AM - 11AM

☐ **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.

(Initials) I have read Arizona Advanced Physical Therapy Office Policies, I understand them and agree to follow them.

Notifier(s):

Patient Name:

Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	PHYSICAL THERAPY		
Reason Medicare May Not Pay:	MEDICARE HAS A \$1,860.00 LIMIT PER YEAR FOR PHYSICAL THERAPY TREATMENT		
Estimated Cost:			

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this. **Note:** If you

Options:	Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.	
<input type="checkbox"/> OPTION 2. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.	
<input type="checkbox"/> OPTION 3. I don't want the _____ listed above. I understand with this choice I am not responsible for payment , and I cannot appeal to see if Medicare would pay.	

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: OMB, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1860.

ATTENTION MEDICARE PATIENTS

To keep up with the constant changes in medicare and to ensure that medicare will cover your physical therapy visits, we strongly urge you to return to your referring physician every 30 days for a re-check.

Please let us know at least 48 hours prior to the appointment with your doctor so we can provide you with a progress report to take with you for the doctor to review, sign and give you to bring back to us.

**Please let us know if you have any questions.
Thank you for your cooperation.**