Arizona OrthoSports Physical Therapy

FOR OFFICE USE ONLY: DATE _____ ICD9 _____

LAST DOC VISIT_____PT _____ CLINIC _____ NEW Pt OR UPDATE

PATIENT NAME _____ SOCIAL SEC# _____ DATE OF BIRTH _____

PERMANENT ADDRESS_____ CITY, STATE, ZIP_____

HOME PHONE _____ BUSINESS PHONE_____ E-MAIL ADDRESS_____

SEX: M F AGE_____

RESPONSIBLE PARTY NAME (IF INDICATED)_____

RESPONSIBLE PARTY DATE OF BIRTH _____ RESPONSIBLE PARTY SS# _____

RELATIONSHIP OF RESPONSIBLE PARTY TO PATIENT: SELF SPOUSE PARENT OTHER

REFERRING PHYSICIAN_____ **HOW DID YOU HEAR ABOUT US?**_____

IS PATIENT: SINGLE MARRIED OTHER **IS PATIENT**: EMPLOYED RETIRED STUDENT OTHER

EMPLOYER NAME: _____

EMPLOYER ADDRESS & PHONE: _____

SPOUSE OR NEAREST RELATIVE'S NAME/ADDRESS/PHONE: _____

DATE OF INJURY _____ IF INJURY RELATED TO AN ACCIDENT, WAS IT: AUTO ACCIDENT OR WORK COMP./JOB RELATED?

LEGAL PROCEEDING PENDING? _____ REPORT SHOULD BE SENT TO ATTORNEY? _____

WHAT PART OF YOUR BODY IS INVOLVED? (ALSO STATE RIGHT OR LEFT SIDE)_____

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME_____	INSURANCE NAME_____
INS. CO PHONE/ADDRESS_____	INS. CO PHONE/ADDRESS_____
POLICY HOLDER NAME_____	POLICY HOLDER NAME_____
RELATIONSHIP TO PATIENT_____	RELATIONSHIP TO PATIENT_____
ID NO_____GROUP/CLAIM#_____	ID NO_____GROUP/CLAIM#_____
POLICY HOLDER SEX: M OR F BIRTHDATE_____	POLICY HOLDER SEX: M OR F BIRTHDATE_____

CONSENT FOR TREATMENT: I understand that I have the right to ask and have any questions answered prior to receiving treatment, including any risks or alternatives to the treatment plan that has been prescribed for me. By choosing a payment option and signing this form, I consent to have an AZOSPT physical therapist provide treatment.

PLEASE CHOOSE ONE OF THE FOLLOWING PAYMENT OPTIONS:

1) I WILL PAY $80.00 SELF PAY RATE, DUE AT TIME OF SERVICE (not applicable for Medicare patients)
SIGNED – Patient or Guardian_____DATE_____

OR

2) BILL MY INSURANCE PER THE REGULAR FEE SCHEDULE: I understand that insurance claims will be submitted to my insurance companies as a matter of convenience. If there should be a third party payer, Arizona OrthoSports Physical Therapy has the right to bill my full-billed charges to that payer. I also understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand.
I hereby assign my insurance benefits to Arizona OrthoSports Physical Therapy for services rendered until my authorization is rescinded.
SIGNED – Patient or Guardian_____DATE_____