Arroyo Physical Therapy, Inc. & Total Rehab

PATIENT INFORMATION

Full Name:_____ Date of Birth:_____ Age:_____

Home Address (Include City, State, and Zip): Height:_____Weight: _____

_____ Home Phone: _____

_____ Cell: _____

Social Security Number: _____-_____-_____ Email: _____

Referring Physician: _____ MD's Tele: _____

Primary Care Physician: _____ MD's Tele: _____

Emergency Contact:_____ Tele: _____

Medications - include dosage & frequency: _____

Allergies: _____

PAYMENT, BILLING, INSURANCE and ATTENDANCE

You must provide accurate insurance information, and it is your responsibility to notify us of any changes. Services are billed as "Arroyo Physical Therapy, Inc.". You will be provided a "**VERIFICATION OF BENEFITS**" form which you must acknowledge and sign. This form explains your *estimated* insurance benefits & responsibility. Unpaid balances may accrue charges each billing cycle unless PRIOR arrangements have been approved. Returned "Non-Sufficient Funds" checks will accrue an additional **$25.00** per occurrence. We may utilize collection services for non-payment.

MEDICARE - Payment from Medicare and your secondary insurance *MAY* cover 100% of our services, NOT including applicable deductibles and co-pays. We cannot bill you for additional charges not covered by Medicare *UNLESS:* **1)** Your secondary insurance has limited reimbursement which requires you to pay the balance, **2)** You were involved in litigation where liability insurance should cover your medical care, **3)** You agree to pay for our services outside of your Medicare coverage and have signed the Medicare ABN form.

PRIVATE INSURANCE: It is important that you verify your benefits prior to receiving services. We do provide complimentary verification of benefits to assist you however remaining balances, co-pays and deductibles are fully your responsibility**.**

CASH: We accept cash, check and credit payments for services which are due at time of service unless prior arrangements are made.

EVAL: _____ FOLLOW-UP VISITS_____

PATIENT INITIALS: (Required for Cash Paying Patients) _____

ATTENDANCE: PLEASE READ CAREFULLY!!!

We are thankful that you have chosen Arroyo PT & Total Rehab for your Physical Therapy needs. To provide you the highest quality care we utilize only highly trained and licensed therapists and render one-on-one therapy sessions for your treatment time. Therefore it is important to diligently keep your scheduled appointments as they are yours and yours alone.

To avoid any charges cancellations *must* be tendered 48 hours prior to your appointment.

First cancellation that is last-minute, or no-show, is charged: $25.00

Second cancellation that is last-minute, or no-show, is charged: $50.00

Third cancellation or no-show occurrence automatically discharges you from our services.

We will bill/invoice you for these cancellations and no-shows by mail. You may pay them by check or utilize our secure credit card payment system on our website: **www.ArroyoPT.com**

I agree to the Cancellation Policy terms and conditions.

_____

Patient Name: Date:

YOUR RIGHTS, ATTENDANCE and FINANCIAL RESPONSIBILITY

I understand that I have the right to respectful and courteous care, and to participate & decide on my care plan. I have the right to access my medical records, and grant or deny access to others. I have the right to refuse treatment. I acknowledge that I have been offered a copy of the Federal HIPPA Privacy Notice. Videos/Photography: videos/ photographs for evaluation and analytical purposes may be utilized with prior notice. These recordings will NOT be made public, and will comply with all HIPPA privacy standards.

Arroyo Physical Therapy & Total Rehab is a HIPAA compliant healthcare company and follows strict State and Federal anti-discrimination policies.

My signature authorizes & acknowledges this contract's policies, disclosures, and my fiscal obligations. I have read & understood this contract and provided accurate & truthful information.

Name of patient's legal representative if signing for patient: _____

Signature: _____ Date: _____