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: _____

_____ 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

All services are billed as "Arroyo Physical Therapy, Inc.". All Clients will be provided a "**VERIFICATION OF BENEFITS**" form which explains your *estimated* insurance benefits as well as your fiscal responsibility, but may not included unforeseen insurance reimbursement changes. 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 utilize collection services for non-payment. **Any Co-Pay's are due at time of services unless PRIOR arrangements have been made.**

MEDICARE: Payment *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, **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.

HOME HEALTH: If you are currently or have recently received ANY HOME HEALTH SERVICES, you may not be qualified for out-patient services. Please provide the following info if we can assist in clarifying your Home Health.

Name of Home Health Agency: _____

Contact Name at Home Health Agency: _____

Telephone Number of Home Health Agency: _____

If you think you are under Home Health you MUST STOP HERE!!!
Please call our office 800-489-6905 x 101 for further instructions.

PRIVATE INSURANCE: Payor benefits will be detailed per your courtesy "Verification of Benefits" review. **Any Co-Pay's are due at time of services. You will be billed for any deductibles.**

SELF-PAY: We **only** accept check and credit card payments for services.
EVAL: _____ FOLLOW-UP VISITS_____
PATIENT INITIALS: (Required for Self-Paying Patients) _____

ATTENDANCE: PLEASE READ CAREFULLY!!!
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 accrues an **additional $50 Fee** and discharges you from our services.
Cancellation fees are due at time of your next visit. 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:

TELEHEALTH / E-Visits: We do offer HIPAA compliant Telehealth / E-Visits that are covered under MOST insurance. By initialing below, you consent to have us contact you for Telehealth / E-visits.
Initials Here:_____

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.**

Name of patient's legal representative if signing for patient and/or who is accepting financial responsibility if other than self or if person is a minor (under the age of 21 or covered under parents policy):

Parents Name(s):_____
Please PRINT Name and Information legibly!
Contact Info:_____

_____

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

Signature: _____ Date: _____