ARIZONA MANUAL
THERAPY CENTERS

Thank you for choosing ARIZONA MANUAL THERAPY CENTERS. Please read each section below carefully, sign and date, and return to the front office personnel. If you have any questions or concerns, please ask us and we will be happy to assist.

AUTHORIZATION FOR TREATMENT

All procedures will be thoroughly explained to you before they are performed. There are certain risks with Physical Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort. The Physical Therapist and/or Physical Therapist's Assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. Based on the above information I agree to cooperate fully and to participate in all Physical Therapy procedures and to comply with the plan of care as it is established.

NOTICE TO PATIENTS: For your safety, do not use any equipment without a staff member present. **Initial** _____

NOTICE OF INFORMATION PRACTICES

I have read and fully understand Arizona Manual Therapy Centers' Notice of Information Practices. I understand that Arizona Manual Therapy Centers may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Arizona Manual Therapy Centers will consider the requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions. I authorize the use and disclosure of my personal health information for purposes as noted in Arizona Manual Therapy Centers' Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. **Initial** _____

DESIGNATED INDIVIDUALS AUTHORIZATION

I authorize the following designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name	Relationship	Name	Relationship
_____	_____	_____	_____

PATIENT INFORMATION CONSENT *(OPTIONAL)*

I authorize Arizona Manual Therapy Centers to use my protected health information for targeted marketing, fundraising and/or solicitation of participation in research studies. I understand that I have the right to copy or inspect any information used for these purposes. I also understand that this authorization does not affect my consent to use my protected health information for treatment, billing or operations related to treatment and billing. **Initial** _____ (optional)

I have read and understand the above information.

_____	**OR**	_____
Patient Name		Legal Guardian Name
_____		_____
Patient Signature		Legal Guardian Signature
_____		_____
Date		Date

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PATIENT INFORMATION

Today's Date:_____

Name(Legal Name, First/ MI/ Last):_____
Prefer to be called:_____ **SS#:**_____
Address (Street):_____ **Apt/ Unit:** _____
City:_____ **State:**_____ **Zip:**_____
Is this a permanent address? ☐**Yes** ☐**No** *If No, What is permanent address?*
Permanent address:_____
Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____
Cell Phone Provider:_____
Employer:_____ ☐ **Retired**
Emergency Contact Name & Phone:_____ **Relationship:**_____

INSURANCE INFORMATION

Primary Insurance:_____
Subscriber/ Relationship:_____ Subscriber Date of Birth:_____
Policy/ ID #:_____ Group #/ Name:_____
Secondary Insurance:_____
Subscriber/ Relationship:_____ Subscriber Date of Birth:_____
Policy/ ID #:_____ Group #/ Name:_____

INJURY OR WORK-RELATED INFORMATION

Insurance Carrier:_____
Claim #:_____ **Claim's Adjustor:**_____
Date of Injury:_____ **State:**_____**Adjustor's Phone:**_____
How did injury happen?_____

CONFIRMATION/ EMAIL INFORMATION

How would you like to have appointments confirmed? Please indicate: ☐**TEXT** ☐**EMAIL** ☐**PHONE CALL**
Email: (*For internal use only*)_____**@**_____

REFERRAL INFORMATION

Referred by:_____
Primary Care Physician, if different:_____

MEDICARE PATIENTS ONLY

Are you currently receiving Home Health Care? ☐**YES** ☐**NO.** If yes, please provide the name & phone number of the agency:_____

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Patient Name:_____ Date of Birth:_____

RELEASE OF INFORMATION & AUTHORIZATION OF BENEFITS

Patient or Guardian Agreement:

☐ I certify that the above information is accurate and true to the best of my knowledge. I authorize release of information requested by my insurance plan for payment.

☐ I assign benefit of payment to Arizona Manual Therapy Centers by my insurance carrier(s). I understand that I am financially responsible for any unpaid balances.

☐ I agree to comply with the terms and conditions as outlined in the Patient Registration form.

Signature of Patient or Guardian:_____ Date _____

Relationship:_____

Medication List (please list all current medications, including prescriptions, supplements, herbs, over-the counter, etc)

If you are a Medicare patient, it is mandatory that we have all of the following information on file.

Medication Name	Why do you take it?	Strength	Frequency/ How often (how many times a day/week) do you take it	How is it Administered (how do you take it? Pill/injectable…)
☐ SEE ATTACHED LIST				

MEDICARE PATIENTS ONLY

- Have you fallen in the past year? ☐ Yes ☐ No
- Have you had 2 or more falls in the past year? ☐ Yes ☐ No
- Did you sustain any injury from a fall? ☐ Yes ☐ No

Patient Responsibilities at Arizona Manual Therapy Centers

Please read and initial each of the following. Sign and date at the bottom.

- I understand that it is my responsibility to know my insurance benefits and policy requirements for all physical therapy services. _____(Initial)
- I understand that it is my responsibility to provide Arizona Manual Therapy Centers with my current insurance information or other method of payment for each visit or service provided. _____(Initial)
- I understand that it is my responsibility to provide a current therapy prescription and/or referral prior to services being rendered. Failure to do so could result in denial by my insurance carrier and all charges will become my responsibility. _____(Initial)
- I understand that failure to update my insurance information, current address and contact information will cause me to become responsible for charges. _____(Initial)
- I understand that it is my responsibility to inform the front desk AND therapist if I have been seen at another clinic for physical therapy, occupational therapy, or speech therapy. _____(Initial)
- I understand that it is my responsibility to provide a prior authorization (if required by my insurance) or letter of medical necessity (if required) from my physician prior to treatment. _____(Initial)
- I understand that it is my responsibility to inform the front desk AND the therapist if my treatment is the result of an injury related to an auto accident, work, or school. _____(Initial)
- I understand that it is my responsibility to keep follow-up appointments as scheduled. My therapy program will require a commitment and being consistent with my appointments is necessary to achieve an optimal outcome. Failure to show for appointments can result in a delay of my Plan of Care. _____(Initial)
- It is my responsibility to notify Arizona Manual Therapy Centers 12 hours in advance if I am unable to keep my scheduled appointment. Failure to do so may result in a $50 no-show/ cancellation fee, which must be paid prior to scheduling my next appointment. _____(Initial)
- Failure to keep 2 consecutive appointments, no-shows, and accounts that no long remain in good faith status may result in termination from Arizona Manual Therapy Centers. _____(Initial)
- Payment is due at the time of service. I understand if I fail to pay my account and it is submitted to an outside agency that a $50 collection fee will be applied to my account. I am responsible for this fee as well as any collection fees and interest allowed by law that may be added to my account.
- I understand that if my account has been forwarded to an outside collection agency, I may not return to Arizona Manual Therapy Centers until I have my previous account has been paid in full and payment arrangements have been made for future services. _____(Initial)

I have read the above and understand my responsibilities as a patient of Arizona Manual Therapy Centers. I have had the opportunity to ask questions and have them answered to my satisfaction. My signature below indicates my acceptance of these terms.

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Or Legal Guardian/ Representative's Signature