ARIZONA ORTHOPEDIC PHYSICAL THERAPY
Feel better. Function better. Live better.

New Patient Information

Please print legibly:

Patient Name_____ Gender: ☐ Male ☐ Female

Patient Address: _____ Patient DOB: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Parent/Guardian (if under 18): _____

Primary Physician: _____ PP Phone: _____

Referring Physician: _____ RP Phone: _____

How did you hear about AZOPT? _____

AZOPT prefers to keep its business "in the family" when possible. Are you involved in a business that could develop a relationship with AZOPT (i.e. graphic design, office supplies, printing, construction, etc.)?

_____

_____

Emergency Contacts

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Primary Insurance Information

Is this injury related to a car accident? ☐ [Y] ☐ [N]

Insurance Company Name: _____

Subscribers Name: _____ Subscribers DOB: _____

ID#: _____ Group/Policy Number: _____

Customer Service Phone Number (Located on back of insurance card): _____

Secondary Insurance Information

Insurance Company Name: _____

Subscribers Name: _____ Subscribers DOB: _____

ID#: _____ Group/Policy Number: _____

Customer Service Phone Number (Located on back of insurance card): _____

If your injury is related to work or an auto accident, please provide our office with the details of your insurance coverage for this incident.

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Patient History

Patient Name: _____ DOB: _____

General Instructions: Indicate Yes or No for each item below. If Yes, indicate your age when it occurred.

Yes/No	Age		Yes/No	Age		Yes/No	Age	
☐		Arthritis/Rheumatism	☐		Asthma/Wheezing	☐		Emotional Problems
☐		Broken Bones	☐		Pneumonia/Pleurisy	☐		Alcohol/Drug Addictions
☐		Dislocated Joints	☐		Tuberculosis	☐		Neuritis/Pinched Nerves
☐		Painful/Stiff Joints	☐		Chronic Cough	☐		Polio or Paralysis
☐		Elbow/Shoulder Trouble	☐		Phlegm or Spitting Blood	☐		Kidney Disease or Stones
☐		Knee Trouble	☐		Breathing Difficulties	☐		Blood Disease or Anemia
☐		Foot Trouble	☐		Swelling of Ankles	☐		Cancer, Tumor or Growths
☐		Head, Neck or Spinal Injuries	☐		Chest Pain or Pressure	☐		Jaundice or Hepatitis
☐		Back Trouble	☐		Rheumatic or Scarlet Fever	☐		Eye Trouble or Injury
☐		Heart Trouble or Murmur	☐		High Blood Pressure	☐		Hernia (Rupture)
☐		Epilepsy, Fits or Convulsions	☐		Diabetes	☐		Frequent/Severe Headaches
☐		Dizziness or Fainting	☐		Hearing Difficulty	☐		HIV/AIDS

General Instructions: Check Yes or No in the appropriate column for the following items. If Yes, please explain:

Yes	No	
☐	☐	Have you ever had any serious ill effects from activities you have done?
☐	☐	Has your activity ever had to be limited or restricted on account of your health?
☐	☐	Do you have any allergies or past allergic reactions?
☐	☐	Do you have any condition, which may require limits to your daily activities?
☐	☐	Have you ever had any surgical operation, or been advised to have one?
☐	☐	Have you ever had an injury or ailment to your neck and/or back?
☐	☐	Have you ever had an injury or operation to either knee or shoulder?

Do you now (as of 1 month ago) smoke cigarettes? YES ☐ NO ☐
How many years have you smoked (did smoke) cigarettes? _____

Please list any and all medications you are currently taking:

_____

WOMEN: Are you pregnant? YES ☐ NO ☐

I, _____, (DOB_____) hereby request and consent to the performance of therapy, including examination and diagnosis, on me by Arizona Orthopedic Physical Therapy, PLLC and other physical therapists and occupational therapists under Arizona Orthopedic Physical Therapy, PLLC supervision. I consent to the treatment plan and intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient/Guardian Signature _____ Date _____

Physical Therapist Signature (Reviewed by) _____

Financial Policies

Please initial each section and sign below:

AZOPT is committed to providing the best possible care, and therefore, your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, financial policy, or your financial responsibility.

AZOPT will request a photocopy of the front and back of your insurance identification card and driver's license. Please update your card with any additional information your insurance company provides, which will facilitate the submission of claims on your behalf. It is your responsibility to inform us of any changes to your policy. We will bill your insurance company on your behalf as a courtesy.

_____ Initial

Co-Payment/Co-Insurance

We must collect your carrier-designated co-pay at the time of service. Refusal to abide by this agreement may result in termination of your coverage.

AZOPT will calculate an estimated co-payment or co-insurance based on your insurance policy. This amount will be due at the time of each appointment.

_____ Initial

Missed Appointments

Patients who do not show up for an appointment, or call to cancel with less than 24 hours' notice have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patients' insurance contract, **we reserve the right to charge a $50.00 fee for no-show or same day cancelled appointments.**

_____ Initial

Returned Checks

If a check is used as your form of payment, and that check is returned due to insufficient funds or the payment has been stopped, you will be charged a $25.00 fee in addition to the amount of the check.

_____ Initial

Insurance

We will gladly bill and accept payment from your health insurance plan. Any amounts not covered by your insurance carrier are your responsibility.

Communication between AZOPT and our patients help us succeed in providing the best care. Please advise us if your insurance company has pre-certification and/or prior authorization requirements and/or policy restrictions and limitations.

_____ Initial

Payments

You are responsible for any amount not covered by your insurance carrier. All co-payments and deductible amounts are due at the time of service. For your convenience, we do accept all major credit cards, checks, money orders, and cash.

Patient or Guarantor

I have read and understand the above. I hereby authorize Arizona Orthopedic Physical Therapy, PLLC to submit claims to my insurance carrier. I hereby authorize direct payment of benefits, otherwise payable to me, to be made payable to Arizona Orthopedic Physical Therapy, PLLC. I understand I will be responsible for payment of any amounts not covered by my insurance carrier, including, but not limited to, co-payments and deductibles.

Signed: _____ Date: _____

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Authorization for the Release of Medical Records

I hereby authorize Arizona Orthopedic Physical Therapy, PLLC to release the medical record(s) of:

Patient's Name: _____

Date of Birth: _____

For the purpose of continued treatment and billing/re-assignment of benefits, this allows AZOPT to bill on your behalf, and for the payment to be sent directly to AZOPT, to:

Arizona Orthopedic Physical Therapy, PLLC
14557 W. Indian School Rd. #500
Goodyear, AZ 85395
Phone: 623-242-6908
Fax: 623-242-6909

Signature of Patient/Guardian: _____

Printed Name: _____ Date: _____

Notice of Privacy Practices

Your name and signature below indicate that you have received a copy of and/or have been directed to the Notice of Privacy Practices by Arizona Orthopedic Physical Therapy, PLLC, on the date indicated. If you have any questions regarding the information set forth in AZOPT's Notice of Privacy Practices, please do not hesitate to ask an AZOPT representative.

Signature of Patient/Guardian: _____

Printed Name: _____ Date: _____

Photo Consent Release

I would like to extend permission to Arizona Orthopedic Physical Therapy, PLLC (AZOPT) to use my:

- Name Yes ☐ No ☐
- Testimonial Yes ☐ No ☐
- Image/photograph Yes ☐ No ☐

in publications and advertisements produced by or for AZOPT. I understand that these publications will also be placed on web sites managed by AZOPT for public relations and advertising purposes. I understand that the publication may appear on the Internet, the publication may appear in print, electronic, or video media, and the publication may enable readers to identify me. I understand this consent is valid until I provide written notice stating otherwise.

Signature of Patient/Guardian: _____

Printed Name: _____ Date: _____