Arroyo Physical Therapy

Patient Information and Responsibility

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

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

_____ Home #: _____

_____ Cell #: _____

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

Referring Physician: _____ MD's Tele: _____

Primary Care Physician: _____ MD's Tele: _____

EMERGENCY CONTACT:_____ **TELE#**_____

BILLING and INSURANCE (Disclosure of Services)
MEDICARE: We will be billing Medicare for services rendered, as Arroyo Physical Therapy, Inc., and this will be seen on your explanation of benefits (EOB). Payment from Medicare and your secondary insurance covers 100% of our services. We cannot bill you for additional charges not covered by Medicare UNLESS:

- You have not met any of your deductibles
- You are receiving therapy elsewhere and did not disclose this to us.
- Your secondary insurance has a deductible or limited reimbursement which requires you to pay the balance.
- You were involved in litigation when liability insurance should cover your medical care.
- You were treated recently and not fully discharged from Home Health therapy and are still under Medicare A coverage
- You have exceeded your yearly $1,920 cap and Medicare refuses to pay. ***I agree to these terms**_____

MEDICATIONS LIST: (Required by Medicare)
Your current medications (Including Dosage and Frequency): _____

_____

_____

PRIVATE INSURANCE: As a courtesy to our patients, we will bill your insurance for you. It is important that YOU verify your benefits and obtain authorization PRIOR to receiving services here. However, we may assist you with this if time allows. Any remaining balance(s), co-pay or deductibles are your responsibility. ***I agree to these terms**_____

CASH: We can accept check or cash payment for therapy services. **PAYMENT DUE AT TIME OF SERVICE!**
You agree to pay: EVAL: $_____ Per Treatment $_____ ***I agree to these terms**_____

***PLEASE READ THIS CAREFULLY AND THOROUGHLY*:**
Accountability, Rights, Attendance, Billing and Scheduling Policy: Cancellation of an appointment requires 24 hour notice. If a 24 hour notice is NOT given, you will be billed **$60.00** for any missed visit and payment may be required prior to receiving any additional appointments/services. A **$20 LATE FEE** will be applied for UNPAID INVOICES every 30 days. Non-compliance of this policy and failure to pay may result in refusal of service. ***I agree to these terms**_____

I understand that I have the right to respectful and courteous care. I have the right to participate and 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 know the risks and benefits of my treatment. I understand that my treatment may at times increase my signs & symptoms, and I have the right to refuse treat-ment. I have provided accurate and truthful information. My signature authorizes this office to bill and collect for services, however, I fully understand that I am ultimately financially responsible for services provided in the event my insurance does not pay or pay fully as required and as stated in the appropriate insurance section above. I have been offered or have received a copy of the HIPPA Privacy Notice.

Signature: _____ Date: _____