

**ARIZONA ORTHOSPORTS PHYSICAL THERAPY**  
**and**  
**InMOTION PHYSICAL THERAPY and WELLNESS**

As a courtesy to our patients, Arizona OrthoSports Physical Therapy will bill your primary insurance carrier. Upon receipt of payment from your insurance company, the allowed balance will be transferred to you. While we accept most insurance, payment amounts vary based on your specific plan. We suggest that you contact your insurance carrier to determine what is covered for physical therapy services by your plan.

**Co payments are due at the time of service. If you have to cancel your appointment, do so in 24 hours in advance. Should you cancel on the same day or not attend a scheduled appointment there will be a \$40 charge for the missed visit.**

An itemized billing statement of the services provided to you is available at anytime per your request. Please ask the receptionist; therapist or you may call the billing office at 602-315-9762.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**PATIENT INFORMATION CONSENT FORM**

I have read and fully understand Arizona OrthoSports Physical Therapy's notice of Information Practices. I understand that Arizona OrthoSports Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of 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 the Arizona OrthoSports Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requested for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Arizona OrthoSports Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

**Patient Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_