

## Arizona OrthoSports Physical Therapy

**FOR OFFICE USE ONLY:** DATE \_\_\_\_\_ ICD9 \_\_\_\_\_

LAST DOC VISIT \_\_\_\_\_ PT \_\_\_\_\_ CLINIC \_\_\_\_\_ NEW Pt OR UPDATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ SOCIAL SEC# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

SEX: M F AGE \_\_\_\_\_

RESPONSIBLE PARTY NAME (IF INDICATED) \_\_\_\_\_

RESPONSIBLE PARTY DATE OF BIRTH \_\_\_\_\_ RESPONSIBLE PARTY SS# \_\_\_\_\_

RELATIONSHIP OF RESPONSIBLE PARTY TO PATIENT: SELF SPOUSE PARENT OTHER \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

**IS PATIENT:** SINGLE MARRIED OTHER \_\_\_\_\_

**IS PATIENT:** EMPLOYED RETIRED STUDENT OTHER \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

EMPLOYER ADDRESS & PHONE: \_\_\_\_\_

SPOUSE OR NEAREST RELATIVE'S NAME/ADDRESS/PHONE: \_\_\_\_\_

**DATE OF INJURY** \_\_\_\_\_ IF INJURY RELATED TO AN ACCIDENT, WAS IT: AUTO ACCIDENT OR WORK COMP./JOB RELATED?

LEGAL PROCEEDING PENDING? \_\_\_\_\_ REPORT SHOULD BE SENT TO ATTORNEY? \_\_\_\_\_

**WHAT PART OF YOUR BODY IS INVOLVED? (ALSO STATE RIGHT OR LEFT SIDE)** \_\_\_\_\_

|  |  |
|--|--|
| PRIMARY INSURANCE<br>INSURANCE NAME _____<br><br>INS. CO PHONE/ADDRESS _____<br><br>POLICY HOLDER NAME _____<br><br>RELATIONSHIP TO PATIENT _____<br><br>ID NO _____ GROUP/CLAIM# _____<br><br>POLICY HOLDER SEX: M OR F BIRTHDATE _____ | SECONDARY INSURANCE<br>INSURANCE NAME _____<br><br>INS. CO PHONE/ADDRESS _____<br><br>POLICY HOLDER NAME _____<br><br>RELATIONSHIP TO PATIENT _____<br><br>ID NO _____ GROUP/CLAIM# _____<br><br>POLICY HOLDER SEX: M OR F BIRTHDATE _____ |
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CONSENT FOR TREATMENT: I understand that I have the right to ask and have any questions answered prior to receiving treatment, including any risks or alternatives to the treatment plan that has been prescribed for me. By choosing a payment option and signing this form, I consent to have an AZOSPT physical therapist provide treatment.

**PLEASE CHOOSE ONE OF THE FOLLOWING PAYMENT OPTIONS:**

1) I WILL PAY \$80.00 SELF PAY RATE, DUE AT TIME OF SERVICE (not applicable for Medicare patients)  
**SIGNED** – Patient or Guardian \_\_\_\_\_ DATE \_\_\_\_\_

**OR**

2) BILL MY INSURANCE PER THE REGULAR FEE SCHEDULE: I understand that insurance claims will be submitted to my insurance companies as a matter of convenience. If there should be a third party payer, Arizona OrthoSports Physical Therapy has the right to bill my full-billed charges to that payer. I also understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand.  
 I hereby assign my insurance benefits to Arizona OrthoSports Physical Therapy for services rendered until my authorization is rescinded.  
**SIGNED** – Patient or Guardian \_\_\_\_\_ DATE \_\_\_\_\_