Alves & Martinez
Physical Therapy & Athletic Performance

PATIENT INFORMATION

Name: _____ Birth date: _____ Sex: ☐ Male ☐ Female

SSN: _____ - _____ -_____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Physical Address: _____ City _____State _____ Zip _____

Mailing Address (if different from above):
_____ City_____ State_____ Zip_____

**** Please provide your contact phone numbers and check your preference:**

☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Other #: _____

Email Address: _____

How would you like to receive appointment reminders? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Doctor: _____ Referral Date: _____

1. Are you presently receiving home care services (therapy, nursing, home health aide)? Yes No

2. Have you recently received home care services, (therapy, nursing, home health aide)? Yes No

If you answer is "Yes" to any of the two questions above. Please provide the following information:

Name of Agency: _____ Phone: _____ Discharge Date: _____

INSURANCE COVERAGE INFORMATION

PRIMARY Insurance: MEDICARE ID#: _____ Effective Date: _____

Insured/Guarantor: _____ Insured/Guarantor DOB: _____ Relationship to patient: _____

MEDICARE INSURANCE DISCLAIMER

As of January 1, 2013, CMS instituted a cap on all outpatient physical therapy. Treatment is capped at $1,900 per calendar year. There is an exception process to this based on medical necessity, but the exception is not applicable in all cases. Please note that any services rendered beyond the annual cap of $1,900 may be your financial responsibility.

SECONDARY Insurance: _____ Insurance Phone: _____

Insurance ID#: _____ Group#: _____

Insured/Guarantor: _____ Insured/Guarantor DOB: _____ Relationship to patient: _____

I acknowledge receipt of Medicare Patient/Secondary Insurance Notice **Initial:** _____

TURN OVER

PRIVATE INSURANCE & MEDICARE PATIENTS:

I hereby assign all medical and or surgical benefits to Alves & Martinez Physical Therapy and Athletic Performance. I understand I am financially responsible for all charges. **Cancellations or missed appointments with less than 24 hours notice to our office are subject to a $50.00 fee**. I hereby authorize release of all information necessary to secure payment. A photocopy shall be considered valid.

Initial_____

Payment Options: AMPT accept personal checks and credit/debit cards. **Insurance deductibles, co-payments/co-insurance are due at each visit**. Any portion of your treatment that is not covered by your insurance becomes your responsibility, and is due within 30 days. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over 30 days old.

Please be aware that you will remain financially responsible for services rendered. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owing and all reasonable costs associated with the collection of this debt, including but not limited to, collection services fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt**. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over 30 days old. A $30.00 fee will be charged to the patient for each check is returned to us with insufficient funds.**

AUTHORIATION and ASSIGNMENT OF BENEFITS

I, the undersigned, do hereby agree and give my consent for Alves & Martinez Physical Therapy and Athletic Performance to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

Initial_____

I have read and fully understand *Alves & Martinez Physical Therapy's Notice of Information Practices.* I understand that Alves & Martinez Physical Therapy 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 Alves & Martinez Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Initial_____

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Alves & Martinez 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.

Initial_____

APPOINTMENT POLICY

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENT ONE WEEK IN ADVANCE TO ENSURE THE TIMES THAT YOU NEED. Appointment times given one week do not automatically follow through to the subsequent weeks.

The patient and the therapist will discuss the importance of the frequency and duration at your first appointment.

Thank you for your cooperation!

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ **Date:** _____