ARIZONA MULTISPORTS PHYSICAL THERAPY LLC

Wellness with Motion
Since 2009

Who may receive your Protected Health Information?

Spouse / Parent / Friend / Significant Other: _____

Date of Birth: _____ / _____ / _____ Age: _____ Phone #: (_____) _____ - _____

May we leave messages regarding test results and appointments on your answering machine? Y ____ N ____

1. I authorize the release of any medical information necessary to process this claim as well as to my physician(s).
2. I request payment of Government Benefits either to myself or to the party who accepts assignments.
3. I also authorize payment of medical benefits to be paid to Arizona Multisports Physical Therapy for services. I understand that I am financially responsible for any balance.
4. I consent to the treatment and/or examination under the supervision of my attending Therapist.
5. I have received Arizona Multisports Physical Therapy's Notice of Privacy Practices and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE YOU.

_____ _____

Patient/Guardian signature Date

Insurance Verification for Office Use

Date: _____ / _____ / _____ Talked To: _____ Phone #: (_____) _____ - _____

Coverage Renewal: _____ / _____ / _____ Visit Limit per Year: _____ Insurance Pays: _____

Deductible per Year: _____ Amount Met: _____ Co-Pay/Visit: _____

Annual Out-Of-Pocket Met: Y / N Amount Met: _____ Authorization #: _____

Verified By: _____

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