Metro Physical Therapy
Scottsdale

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Thank You for choosing Metro Physical Therapy Scottsdale!

We look forward to assisting you with your rehabilitation and suggest you read the following to help answer some questions you may have starting physical therapy at our clinic.

Scheduling appointments:
When scheduling your initial appointment, please have the name of your referring physician as well as your insurance information ready. We verify insurance benefits with your carrier as they relate to physical therapy prior to your first appointment, therefore this information is helpful. We will explain your benefits and patient responsibility to you at your first visit. We suggest return/follow-up visits be scheduled in advance so that times convenient for you are available. Please note that it is very important that you are prompt for your scheduled appointment time. You will be scheduled for a half hour of hands on contact with your therapist. Arrivals over ten minutes late will be rescheduled or treatment time will be shortened so that fellow patients are not affected adversely. Chronic tardiness and missed or cancelled appointments affect your level of recovery and may prolong or complicate your rehab experience.

Insurance requirements:
Most insurance companies require a written prescription from your doctor that states the frequency and duration for physical therapy. Prescriptions are good for about a month and must be kept current. Please make certain to bring your prescription as well as your insurance cards to your initial visit. Authorization (if necessary) will be obtained by our front office staff and may require you to complete a questionnaire about your condition. All other patient intake paperwork is available on this website. Please download, complete and bring with you to your first visit. Or if you prefer, arrive 20 minutes early to complete the paperwork at our office prior to your first visit.

We look forward to working with you and encourage you to communicate any questions or concerns you might have. Communication is an important aspect of your treatment, so please let us know of upcoming visits with your physician as well as any procedures or tests ordered such as injections or MRIs. Your therapist will communicate regularly with your physician to provide a status report on how you are progressing.

We strive to make your rehabilitation as effective and pleasant as possible. Again, thank you for allowing us the opportunity to assist in your care.

The staff of Metro Physical Therapy Scottsdale

METRO PHYSICAL THERAPY

PATIENT INTAKE INFORMATION

Date_______________

Patient Information

Name____________________________________Sex________Marital Status___________________

Address____________________________________City_________________________Zip_________

Home# ________________________________Mobil#
_____________________Work#___________________

SSN **XXX-XX-**__________ Date of Birth _____________Employer___________________________
(Last 4 digits only)
E-Mail Address ______________________________Referring Physician________________________

Is your condition/injury due to an accident? Auto Work Other

If this is a work related injury:

Date of injury_________________ Employer at time of injury__________________________________

Insurance Company _____________________________ Phone# ______________________________

Adjuster Name _______________________________Adjuster Phone#__________________________

Claim# ___________________________________

Patient Emergency Contact Information:

Name____Relationship____________________

Phone# _____________________________ Alternate Phone# _________________________________

Insurance Information (Primary)

Insurance Company ___________________________________ Phone#__________________________

Name of Insured ____________________________________ Relationship to Patient_______________

Insured (if not patient): SSN **XXX-XXX-**_________Date of Birth _____________________(MM/DD/YYYY)

Policy # ________________________ Group# ________________________ID# ___________________

Secondary Insurance Information (Medicare Patients Only)

Insurance Company ___________________________________ Phone#__________________________

Name of Insured ____________________________________ Relationship to Patient_______________

Insured (if not patient): SSN **XXX-XXX-**_________Date of Birth _____________________(MM/DD/YYYY)

Policy # ________________________ Group# ________________________ID# ___________________

METRO PHYSICAL THERAPY

PATIENT INTAKE INFORMATION

Patient Name: ____**Date**_____/____/____

Referring Physician: ____**Onset of injury**_________________

Medications you are taking:

____
__

____

Please mark on the scale below your pre-injury level of function. (Please circle)

1%-----10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%------90%-----100%

Please mark on the scale below your present level of function. (Please circle)

1%-----10%-----20%------30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Please describe below the area of your **discomfort / pain location/** .

____

____

____

Please indicate which, if any, of these words describe your pain. Mark all that apply.

□Throbbing □Sharp □Aching □Tingling □Burning □Numb □Shooting

Rate your current pain intensity on a scale of 0-10. (0 being no pain).________________

Which activities increase your symptoms? Mark all that apply.

□ Sitting □Walking □Driving □Kneeling □Twisting □Standing □Reaching □Stairs

□Reclining □Lifting □Bending □Squatting □Rising □Other__________________________

What eases your symptoms?

□Moist heat □ Ice application □Medication □Rest □Change in position

□Other____

Is your condition overall:

□Improving □Getting worse □Staying the same

Have you had any treatments for this current problem in the past? □Yes □No

Have you received any of the following tests for this problem?

□X-rays □CT Scan □Bone Scan □EMG □Nerve Conduction Study □MRI □Other:___________

Metro Physical Therapy Scottsdale

Medical Assignment of Benefits & Financial Policy

We at Metro Physical Therapy Scottsdale are pleased to be a part of your rehabilitation experience and we thank you for choosing us. We find that communication with our patients regarding our financial policy assists in providing the best service to you.

Insurance Billing

We will gladly call your insurance company to identify your benefit coverage; however, please understand **that insurance companies will not guarantee medical benefits over the phone**. We can only use this information as an estimated guideline. Actual determination to pay claims is made when the insurance company processes the claims several weeks later. We strongly encourage you to contact your insurance company directly in order to fully understand your plan's coverage and limitations. Please note that we will only bill up to two insurance companies (primary and secondary) for MEDICARE related claims, and only one insurance company (primary) for all other claims.

Your insurance company may also require a current therapy prescription (prescriptions expire 30 days from the date they are written) a letter of medical necessity written by your physician and/or pre authorization directly from your physician. It is your responsibility to obtain these requirements and non-compliance may result in services not being covered by your insurance company. **If your insurance company denies your claims, you are financially responsible for all services rendered**.__________(initial)_

Payments

All deductibles, co-pays, co-insurance and cash pay estimated amounts are due at the time of service unless other written arrangements have been made with our facility. **So that account balances remain current, co-pays and co-insurance will be collected on a weekly basis______________(initial)**

Once we have received all payments or notifications from your insurance company we will present you with your final statement. Payment for any outstanding balance will be due in full no later than 30 days from the date of your final statement. If we do not receive payment within 30 days, we may pursue legal collection proceedings and you will be responsible for an additional 35% collection fee. Please do not hesitate to ask us any questions or request a copy of your account balance status.

Cancellation Policy

Metro Physical Therapy Scottsdale may charge my account for any appointment missed with less than 24 hours notice for an amount of $25.00. **This cancellation fee is not covered by my insurance company and I accept full financial responsibility for all cancellation charges__________________(initial)**

I acknowledge that all of the information supplied on the patient registration form is true and correct and I have read, understand and agree that I am 100% responsible for all fees incurred at Metro Physical Therapy Scottsdale. I agree to authorize Metro Physical Therapy Scottsdale to release my medical information to insurance companies, physicians, attorneys and all pertinent parties that may be involved in my claim or care. I also agree to assign all payments of benefits to Metro Physical Therapy Scottsdale.

Patient Name (please print)____________________________________

Patient (or legal guardian/responsible party)_________________________________

Date_______________________