Rio Rancho Physical Therapy, Inc.
4516 Arrowhead Ridge Dr SE
Rio Rancho, NM 87124
Ph: 505-896-4978
Fax: 505-994-2842

Patient Intake Form

Patient Information:

First Name: _____ MI:_____ Last Name: _____

D.O.B.:_____ SS #: _____

Mailing Address: _____

City/State/Zip: _____

Email Address: * _____

Home Phone*:_____ Cell Phone*: _____

work Phone*: _____

*By providing this information, you are consenting to receive phone calls/or text messages or emails at the information provided.

Emergency Contact: _____ Phone# _____

Parent/Guardian/Guarantor Information Qf Other Than Patient):

First Name: _____ MI: _____ Last Name: _____

DOB: _____ SS # _____

Relationship to Patient: _____

MaiIing Address
(If different from patient): _____

City/State/Zip: _____

RIO RANCHO PHYSICAL THEREAPY
PATIENT FINANCIAL RESPONSIBILITY FORM

The patient (or patient's guardian, if a minor) is ultimately responsible for payment at the time of service for his/her treatment of care. Patients are responsible for co-pays, co-insurance, deductibles, and all other treatments not covered by their insurance plan, which is due at the time of service.

If your insurance has changed or you have more than one policy the patient is required to provide us with the correct and updated information and will be responsible for any charges incurred if the information provided is not correct or updated. We will not bill secondary insurance if information is not received on first visit.

Common Reasons for insurance claim denials include but are not limited to:

- **Insurance not in effect at the time of service**
- Patient has NOT met policy deductible
- **Coverage by more than one Plan in which coordination of benefits has not been arranged**
- **Policy maximum has been reached**
- Medical services rendered is not covered by the insurance policy
- lfyou fail to disclose auto 3" party claim. (auto related injury)
- Pre-existing medical condition(s)
- Failure to disclose treatment at another facility

*****If any changes in your insurance information coverage is not provided or received within the insurance carriers timely filing period, the patient will become responsible for any balance on the account.*****

Workers' Comp/Auto
We cannot file claims to worker comp program unless your adjustor has authorized your treatment. We can file automobile-related accident claims only if we are going through **YOUR** own auto insurance.

We DO NOT bill 3rd party claims 11or do we accept letter of protection.

Self Pay
Full payment is due at the time of service.

Balance Due
We will send a statement to your billing address notifying you of any balance due. Any unpaid balance is patient's responsibility and payment in full is due upon receipt of the statement. Payment not made within 60 days of statement date will be considered delinquent.

IF YOU AIRE UNABLE TO PAY THE BALANCE DUE IN **FULL, YOU MUST CONTACT OUR OFFICE TO DISCUSS POSSIBLE PAYMENT OPTIONS WITHIN THE 30 DAYS.**
I understand and agree that my account will be considered delinquent and sent to RRPT, Inc.'s collection attorney if payment arrangements are not made upon demand. I understand and agree that interest will be charged on all accounts at 18% per year, from 30 days after last date of service. I do hereby to the above payment conditions and accept responsibility for payment of treatment costs, all attorney fees, plus other collection costs and charges necessary for collection of any amount not paid when due.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

Signature of Responsible Party _____ Date _____/_____/_____

Rio Rancho Physical Therapy

Policy Statements

ALL PATIENTS ARE RESPONSIBLE FOR SUPPLYING ACCURATE INSURANCE INFORMATION , ATTORNEY AND/OR FINANCIAL INFORMATION BEFORE INITIAL EVALUATION DATE.

The patient's contract is with their insurance company. Even if an insurance claim is filed, this office is not responsible for collecting your claims or for negotiating disputed claims. The patient assigns benefits directly to Rio Rancho Physical Therapy. It is not the policy of RRPT to bill third party insurance companies. In the case of a Motor Vehicle Accident (MVA) we will bill the patient's auto insurance for medical payments; if none are forthcoming then RRPT will bill the patient's primary health insurance. It will be the patient's responsibility to pay any non-covered service, co-payment, co-insurance and/or deductible payment to this facility.

Is this AUTO related? _____Yes _____No Date of Injury ___/___/___

Is this WORK related? ____Yes _____No Date of Injury ___/___/___

Consent to treat:

I hereby give written consent to be evaluated by a licensed physical therapist and treated by the same therapist and/or his/her supervised technician employed by this facility.

I permit a copy of this authorization to be used in place of the original. I also authorize the faxing and release of medical information to and from all professionals involved in the care of my present medical condition.

Patients signature: _____ Date: ___/___/___
(Parent's signature if minor)

Rio Rancho Physical Therapy
Late, Cancellation, and No-Show Policy

Rio Rancho Physical Therapy values all of our patients and their needs. We attempt to provide care to all of our patients in a timely matter. We ask our patients to be respectful and courteous to fellow patients and their treatment needs, as well as our therapist's schedule. We ask that you are courteous in scheduling your therapy appointment for a time when you do not have conflicting agendas. If you find that you do have a conflicting agenda, and are unable to attend your appointment, we require a 12-hour cancelation notice. This allows our office to fill your appointment time with another patient in need of care.

Late Policy

If a patient is late for an appointment, we ask that you call and let us know you are on your way. However, if you are more than ***15 minutes late*** you may have to reschedule your appointment.

Cancellation of appointment(s)/ No-Shows

Patients wanting to cancel an appointment are asked to call the office 12 hours in advance to avoid an inconvenience charge of $25, not payable by any insurance company.

Patients who "No-Show/No-Call" for the **Initial Evaluation** will be charged a $50 inconvenience fee before rescheduling, not payable by any insurance company.

Patient who "No-Show/No-Call" with no previous notification **2 times** for scheduled appointments will be discharged from treatment. If patient still desires to continue treatment, you will be charged a $50 inconvenience fee.

Informed Consent/ Agreement

☐ I have been informed of and understand the facility's late policy.
☐ I have been informed of and understand the Rio Rancho Physical Therapy's No Show/Late Cancellation Policy. I understand that a no-show or late cancellation will result in a charge that is not covered by any insurance. I understand that 2 no shows for scheduled appointment will result in dismissal from the facility.

Signature of Patient/Guardian: _____ Date: ___/___/___
(Parent's Signature if Minor)

Exhibit C - Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by RIO RANCHO PHYSICAL THERAPY, INC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 4516 ARROWHEAD RIDGE DR. SE, RIO RANCHO, NM 87124, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____ Other (explain) _____

_____ _____
Signature of Authorized Practice Representative Date