**NEW PATIENT PAPERWORK: PATIENT INFORMATION**

**GENERAL INFORMATION:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date: | Patient Name: | | | Date of Birth: | | | Social Security Number: |
| Home Address: | | | | | | City / State / Zip: | |
| Mailing Address (If Different): | | | | | | | |
| Email Address: | | | | | | | |
| Phone (Preferred):  Home  Cell | | | Phone (Alternate):  Home  Cell | | | | |
| Primary Care Physician: | | | Primary Care Physician Phone: | | | | |
| Emergency Contact: | | Phone: | | | Relationship: | | |

**BILLING INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| Responsible Party: | Responsible Party DOB: | Social Security Number: | Relationship to patient: |
| Address: | | | |
| Phone: | | | |
| Primary Insurance: | | Phone #: | |
| Policy Holder: | | Claims Address: | |
| City / State / Zip: | | ID / Policy #: | Group #: |
| Credit Card #: | | Exp. Date: | Cardholder Name: |

The person listed above in the Responsible Party section is responsible for payment of all services rendered. AICCD will file claims to your insurance company and will also provide any requested documentation. Any amounts unpaid by insurance in 45 days will become the responsibility of the person listed above. Insurance company denials of claims will result in the denied amount becoming the responsibility of the person listed above. For clients seeking third-party reimbursement, please be aware that you are ultimately responsible for the payment of services rendered.

**FINANCIAL RESPONSIBILITY**

I hereby accept all responsibility for treatment costs not covered or reimbursed by third party payers.

The undersigned certifies and he/she has been explained the treatment costs and is the responsible party.

Date Responsible Party (Please print) Responsible Party Signature

**PATIENT INFORMATION ACKNOWLEDGEMENT**

It is your responsibility to be aware of your benefits. If you are unsure of your insurance benefits, please contact your insurance provider for clarification of your benefits.

Please bring your insurance card to each appointment. If you change insurance companies or benefits, you must call our office with the new information at least 48 hours prior to your appointment. If you fail to notify us of changes to your policy or benefits, you will be responsible for the bill.

All insurance information, including referrals and claim forms (when necessary), must be provided at the time of service. Please be sure to verify that the referral has been received two (2) business days prior to your appointment. We cannot see you without a valid referral if a referral is required by your insurance company.

All co-pays, deductibles, and payments are due at time of service, with co-pays collected prior to seeing the therapist. We accept credit card, cash, and personal checks only.

Any personal checks returned to us from your bank will be subject to a fee of $25.00.

Once your insurance has been paid, any balance remaining after the first billing will accrue a finance charge of $1.50 to 1% monthly on the balance due. Any account left unpaid after 120 days will be turned over to an outside collection agency. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go to our collection agency, any arrangements/payments will need to be made directly with/to the collection agency. In addition, once an account has been turned over to the collection agency, the patient will receive a letter of discharge from our practice.

Please retain copies of all patient receipts. A $20.00 charge will be made for end of year statements for tax purposes.

Although we will require you to fill an update on your first appointment of each calendar year, it is your responsibility to notify our office immediate of any change of name, address, phone number, or insurance coverage.

I have read the above patient information and understand and agree to these terms.

Date Responsible Party (Please print) Responsible Party Signature

**ASSIGNMENT OF BENEFITS**

I hereby authorize (Insurance Company) to pay directly to the Arizona Institute for Communication and Cognitive Disorders all benefits due me, if any, by reason of services described in the statements rendered, and as provided for in the above policy contract with aforementioned insurance company.

I will pay at the Arizona Institute for Communication and Cognitive Disorders, Phoenix, Arizona for all such charges incurred or for all charges in excess of whatever sums may be paid by the insurance company mentioned above. I understand that the Arizona Institute for Communication and Cognitive Disorders which as accepted assignment; has the same right as I do to appeal carrier's determination.

Please note that the Arizona Institute for Communication and Cognitive Disorders is unable to submit claims to Medicare or AHCCCS.

Patient or person assuming financial responsibility

Insured, if other than person signing above Date

**CONDITIONS FOR TREATMENT BY ARIZONA INSTITUTE FOR COMMUNICATION & COGNITIVE DISORDERS**

RELEASE OF INFORMATION: AICCD may disclose all or part of the patient's records to any person or corporation which is or may be liable under a contract to the agency or to the patient or to a family member or employer of the patient for all or part of the agency's charge, including but not limited to, hospital or medical service companies, insurance companies, workman's compensation careers, welfare funds, or the patient's employer.

TREATMENT CONSENT: The patient is under control of his/her physician and the undersigned consents to any treatment or procedures rendered the patient by the Institute under the general and specific instructions of the physician. It is further understood that the Institute is authorized to carry out all instructions of the patient’s physician and that the Institute is hereby relieved of any and all liability occurring from the physician’s instructions.

I request and authorize the staff of the Arizona Institute for Communication and Cognitive Disorders to provide me with treatment, and to perform any therapy now contemplated or such additional therapy as my physician may deem reasonable and necessary.

The undersigned certifies that he/she has read the aforementioned information and is the patient, or is duly authorized by the patient’s general agent to execute the above and accept its terms.

Patient or person assuming financial responsibility

Insured, if other than person signing above Date

**SUMMARY OF BILLABLE CHARGES**

1 hour session is equivalent to: 1.5 hour session is equivalent to: 2 hour session is equivalent to:

50 minutes of clinical time 1 hour 15 minutes of clinical time 1 hour 40 minutes for clinical time

10 minutes for charting 15 minutes for charting 20 minutes for charting

For every half hour of clinical time, 5 minutes are allowed for charting. Clinical time includes:

1. Direct client contact

2. Contact with family members regarding client

3. Contact with other professionals regarding client (doctors, other providers, attorney)

4. Time spent writing reports/letters for clients

Contact can be in person, on the telephone, as well as by email, letter, or fax.

**ADDITIONAL INFORMATION**

Phone consultation, meeting and missed appointments are all subject to billing. Our policy on cancellation and missed appointments is as follows: If you must cancel or change your appointment, please give at least 48 hours notice. A message may be left at the office or with our voice messaging system (602-224-0202). If you fail to give the required notice, you will be charge $65.00 and will be payable at the time of your next appointment. Insurance companies will not pay for any missed appointments so it is to your advantage to give 48 hours notice. If you miss two appointments, you will be taken off our schedule permanently, unless prior arrangement has been made with our clinical director. With respect to make up appointments, they will be allowed only for illness and/or being out of town. Thank you for your cooperation! Please keep in mind that we have a flexible schedule which can usually accommodate your scheduling needs.

The undersigned certifies that he/she has read the aforementioned information and is the patient, or is duly authorized by the patient’s general agent to execute the above and accept its terms.

Date Responsible Party (Please print) Responsible Party Signature

**OFFICE POLICIES AND PROCEDURES**

In order to provide each client with efficient and effective treatment there are several policies and procedures that need to be reviewed prior to initiating treatment. They include the following:

* Each new client will be evaluated in order to determine the strengths and weaknesses of each individual in order to develop an appropriate treatment plan.
* Once the evaluation and treatment plan have been completed, they will be reviewed with the clinician. Please allow a reasonable amount of time for the report to be completed. We strive to be timely and the process should take no longer than two weeks. Also, please keep in mind that if authorization from an insurance company is required to initiate therapy, the process may be delayed.
* Following the completion of the evaluation, the client and clinician will meet for an agreed upon number of sessions per week. If a session is cancelled with less than 48 hours notice, the client will be charged, unless there is an extreme emergency. If for unforeseen reasons a clinician needs to cancel a session, the session will be made up as soon as possible.
* The support staff in the office is very busy; phone calls to the office should be limited to no more than five minutes per call. Please feel free to leave a message for the clinician with the office. All calls will be returned within one business day (24 hours, excluding weekends, unless there is an emergency).
* All arrangements for billing need to be completed in advance with the office-billing manager.
* Mutual respect and decorum is necessary to have effective treatment. If client is verbally abusive to either administrative or clinical staff, client will be discharged from our care.

Your signature below will indicate that the office policies and procedures have been read and that you understand that guidelines. If you do not understand the policies, please address questions to the clinicians.

Date Responsible Party (Please print) Responsible Party Signature

MCNA02448_0000[1]ARIZONA INSTITUTE FOR Phone: 602-224-0202

COMMUNICATION AND Fax: 602-224-0010

COGNITIVE DISORDERS mjtrunzo@mindspring.com

4545 N. 36th St. Ste 125A Phoenix, AZ 85018 http://www.aiccd.net

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I hereby authorize: (Name of Doctor or Medical Office)

(Address)

(City, State, Zip)

to release copies of all medical records compiled during office visits and/or hospital admission for the following patient:

Patient Name:

Patient Date of Birth:

Patient SSN:

Please deliver to:

AICCD

4545 N. 36th St. Suite 125C

Phoenix, AZ 85018

Phone: 602-224-0202

Fax: 602-224-0010

All of my medical records, charts, files, prognosis, reports, x-rays, laboratory reports, clinical records, and such other information relative to m y medical condition or my treatment at any time provided to me and all to the extent said information is available and within your possession. You are further requested not to disclose any information concerning my past or present medical condition to any other person without my express written permission.

Please include all **ICD-10 codes** for individual.

Thank you for your cooperation.

Date Patient Name (Please print) Authorized Signature

**COMMUNICATION CONSENT FORM**

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this Communication Consent Form.

The Arizona Institute for Communication and Cognitive Disorders (AICCD) will not release confidential and/or other Protected Health Information (PHI) by home mailing, home telephone, answering machine, work telephone, voice mail, cell phone and or/pager. When we place telephone calls and an answering machine responds, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I, authorize AICCD to contact me and or named authorized person(s) and to convey PHI by the following methods and assume responsibility to notify AICCD whenever this information changes:

Home Mailing  No  Yes

Home Telephone  No  Yes Number:

Answering Machine  No  Yes Number:

Work Telephone  No  Yes Number:

Voice Mail  No  Yes Number:

Cell Phone  No  Yes Number:

Who may we contact in case of an emergency?

Name: Relationship: Phone:

Please list names of other people authorized to receive information about your care.

Spouse:

Parent:

Other:

Date Patient Name (Please print) Authorized Signature

Parent/Guardian Signature (if needed)

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this Communication Consent Form.

The Arizona Institute for Communication and Cognitive Disorders (AICCD) will not release confidential and/or other Protected Health Information (PHI) without your prior authorization.

I, authorize AICCD to contact me and or the below named authorized person(s) to convey PHI and assume responsibility to notify myself or the following person(s) whenever medically necessary:

Name: Relationship:

Phone Number: Alt. Phone Number:

Name: Relationship:

Phone Number: Alt. Phone Number:

Name: Relationship:

Phone Number: Alt. Phone Number:

Date Patient Name (Please print) Authorized Signature

Parent/Guardian Signature (if needed)