Sandia Sunrise Therapy
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Patient Name: _____
Date of Birth: _____

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION:

Legal Name: _____ Age: _____ Male: _____ Female: _____
Date of Birth: _____ Referring Primary Care Doctor: _____

Please check if it is okay to leave a message: ☐ **Yes** ☐ **No**
Home Ph: _____ Cell Ph: _____
Work Ph: _____ Email: _____

Mailing Address: _____ City, State, Zip: _____
Occupation: _____ Employer: _____

INSURANCE INFORMATION: *Please fill out ALL areas*

Primary Insurance: _____
Policy Number: _____
Group Number: _____
Insured's Name: _____
Insured's DOB: _____

Secondary Insurance: _____
Policy Number: _____
Group Number: _____
Insured's Name: _____
Insured's DOB: _____

Please initial the following statement:

_____ I **DO NOT** HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED.

EMERGENCY MEDICAL RELEASE:

In the event medical attention is required for you, Sandia Sunrise Therapy LLC needs your authorization to implement:

I, _____, give my permission for Sandia Sunrise Therapy LLC to contact emergency personnel in the event of a medical emergency.

_____ _____
Patient Signature Date

EMERGENCY CONTACT:

NAME: _____ PHONE: _____

RELATIONSHIP: _____

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TECHNOLOGY PERMISSION:

Please **initial** the following OPTIONAL statements:

_____ **EMAIL:** I give permission to Sandia Sunrise Therapy LLC (SST) to correspond with me via e-mail regarding treatment, documentation, and home programming. I understand that SST e-mail is encrypted internally; however once an email is sent externally, correspondence may potentially be intercepted by an outside party.

_____ **TEXT:** I authorize Sandia Sunrise Therapy LLC (SST) to send text messages to my cell phone related to appointment reminders. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply to any messages received from SST. I agree not to hold SST liable for any electronic messaging charges or fees generated by this service. I understand that SST text messages to my cell phone are not secure and potentially could be intercepted by an outside party.

AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS:

Please **initial** the following statements:

_____ I hereby give Sandia Sunrise Therapy LLC (SST) permission to evaluate and treat. I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and SST staff.

_____ I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ _____
Patient Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):

I acknowledged that I have viewed, read, and understand the HIPAA Policy (attached at the end of this packet) and have been informed of my rights as a patient.

_____ _____
Patient Signature Date

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PATIENT AGREEMENT:

Please carefully read and review the following policies

MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE:
Insurance companies may have limits on the amount of Physical and/or Occupational Therapy services covered. Once you have exhausted the limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of these services. While this practice will not discontinue your services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements.

Should your insurance coverage change, our office must be notified within 30 days of the effective date. If you fail to provide us this information, your account and future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance carrier. Payment will be due at time of service in full.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. ***Please note insurance companies may indicate the services were not medically necessary and claim that, because Sandia Sunrise Therapy LLC is a preferred provider, you do not have to pay the balance. This is NOT the case and you will be billed for the services.*** This office cannot accept responsibility for negotiating settlements on disputed claims.

Please **initial** the following statements:

_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.

_____ I give Sandia Sunrise Therapy LLC permission to submit bills directly to the insurance carrier.

COLLECTION OF PAST DUE ACCOUNTS:
We communicate with our patients to resolve past due accounts in all cases. If we cannot reach a patient by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

FINANCIAL AGREEMENT:
New patients approved for Physical Therapy and Occupational Therapy services are responsible for any and all charges not paid for by healthcare insurance payors (Medicaid, private health insurance carriers, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Sandia Sunrise Therapy LLC for the services we provide to you, our valued customer. We accept cash, personal checks, and credit cards (VISA, MasterCard, and Discover Card). ***Any returned checks will be subject to a NSF fee of $25.00 which will be due at the next visit. Accounts that are past due will incur a finance charge at the rate of 18% annually.*** We also are willing to make reasonable payment arrangements to keep your account current. If arrangements are needed, please contact our Billing Office.

PATIENT STATEMENT OF AGREEMENT:
My signature below signifies that I have read and understand this patient agreement for Sandia Sunrise Therapy LLC to provide me Physical and/or Occupational Therapy services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

_____ Patient Signature

_____ Date

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CANCELLATION POLICY

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, ***please discuss schedule changes at the end of your appointment with your therapist and the front desk***. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule an appointment. This allows for patients to reschedule into additional openings therapists may have. For Monday morning appointments, our office appreciates being notified no later than Friday noontime.

Please review and initial all statements below:

_____ I understand it is my responsibility to communicate to the front desk any schedule changes or appointment cancellations.

_____ If a therapy session is not canceled prior to an appointment time or is missed without any notice, this missed appointment is counted as a no-show which will result in a charge of a $50.00 no-show fee. ***Note: Insurance companies DO NOT reimburse for no-show fees; this is the responsibility of the patient.***

_____ Three consecutive no-shows may require you to be taken off the schedule and placed back on the waitlist.

_____ We require an 80% attendance rate and may need to remove the patient from the therapist's schedule if efforts are not made to maintain this rate. Note: We calculate attendance quarterly and, as a courtesy, will notify you if your percentage drops below the required 80%.

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for more than three weeks, (such as for an extended trip), we will place you back on the waitlist and will fit you back in the schedule as soon as we can.

I hereby understand the above cancellation policy and agree to abide by it.

_____ Patient Signature

_____ Date