Adult Client Information

Questions? Contact Heather Holston, 480-365-9981, HeatherHolston@rztherapy.com

Patient Information

Last Name: _____ First Name: _____ Birthdate:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ *Preferred: Home or Cell*

Primary Insurance Information

Insurance Co. Name:_____ Telephone: _____

Insurance Co. Address:_____ City:_____ State:_____ Zip:_____

Policy/ID Number:_____ Group ID Number: _____

Primary Policy Holder: Self Spouse

Last Name: _____ First Name: _____ Birthdate:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ *Preferred: Home or Cell*

Secondary Insurance Information

Insurance Co. Name:_____ Telephone: _____

Insurance Co. Address:_____ City:_____ State:_____ Zip:_____

Policy/ID Number:_____ Group ID Number: _____

Secondary Policy Holder: Self Spouse

Last Name: _____ First Name: _____ Birthdate:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ *Preferred: Home or Cell*

By signing below, I agree that all of the above information is correct:

Signature: _____

Printed Name:_____ Date: _____

Patient Name:_____ Date of Birth:_____

Release and Assignment (Please Initial Each Line):

_____I understand I will be charged $50.00 if I do not cancel 24 hours prior to my scheduled appointment time, no exceptions or waivers granted.

_____I understand that I am responsible to pay my co-payment in full at the time of my scheduled appointment.

_____I have insurance coverage and assign directly to Ridge Zeller Therapy any and all medical benefits, if any, otherwise payable to me for services rendered.

_____I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan.

_____I understand that if such an agreement has been executed, I am responsible to pay any deductible and/or co-payment and noncovered services under the terms of my insurance.

_____I understand that I am financially liable in the event of non-payment.

_____I understand that all balances due are due in full within 90 days of each date of service. If my bill is not paid in full within 90 days of each date of service, a 10% interest charge will be added for each month thereafter. We also reserve the right to send your account to collections after 90 days.

_____I agree to pay the collection agency's cost and / or court costs and reasonable attorney fees.

_____I understand that it is my responsibility to provide a referral letter prior to being seen if my insurance requires it.

_____I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to Ridge Zeller Therapy for any services furnished me by that party who accepts assignments/physician. Regulations pertaining to Medicare assignment of benefits apply.

_____I authorize any holder of medical or other information about me be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim/other Insurance Company claim.

_____**I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment.**

_____I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.

By signing below, I am consenting to all of the above:

Signature of patient or representative: _____ Date:_____

READ AND SIGN:

I have read the 'Notice of Privacy Practices' form and was provided a copy for my records (see next page). This Notice describes how Ridge Zeller Therapy may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I also understand that the 'Notice of Privacy Practices' form is available by calling our office at 480-365-9981.

Signature of patient or representative:_____ Date:_____

3160 North Arizona Avenue, Suite 105
Chandler, Arizona 85225
Phone: 480-365-9981
Fax: 480-963-9126

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.

WE ARE REQUIRED BY LAW to provide you with this notice that explains our privacy practices regarding your medical information and how we may use and disclose your protected health information for treatment, payment, health care operations, and any other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information that we also describe in this health notice.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatments: We will use and disclose your protected health information to provide treatment. For example, information obtained by a clinician or other member of our staff will be recorded in your records and used to manage your health care. We may also disclose your information to other physicians, providers, or support coordinators involved in your care including the referring physician or a specialist we have referred you to see.

Payment: We will use and disclose your protected health information to obtain payment for services we provide. For example, we may contact your health insurer to verify coverage and we may provide your insurer with details of your treatment including diagnosis and procedures. We also may contact a third party who may be responsible for payment such as a spouse, parent, or family member. We may also use the information to bill you directly for services.

Health care operations: We may use and disclose your protected health information to operate our business. For example, we may disclose your health information to third party business associates who perform billing and consulting services.

Appointment reminders: We may contact you to remind you of an appointment or to make appointments for periodic check-ups.

Others involved in your care: We may discuss your protected health information with a family member, friend, or any other person identified that is involved in your medical care.

As required by law: We may disclose your information when we are required to do so by federal, state or local law.

To avert a serious threat to public health or safety: We will use and disclose your information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease or injury.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A paper copy of this notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by printing a copy from our website.

Inspect and copy: You have the right to inspect and copy protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we may use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection by copying law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to:

Ridge Zeller Therapy, LLC
3160 North Arizona Avenue, Suite 105
Chandler, Arizona 85225

You may mail your request or bring it directly to our office. We will have 30 days to respond to your request and are allowed up to 60 days to respond but must inform you of this delay.

Request amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our privacy officer stating exactly what information is incomplete or inaccurate, and your reasoning that supports your request. We are permitted to deny your request if the information was not created by us or the person who created it is no longer employed by the facility.

Permission to Release Information

Communication between professionals is critical in providing a comprehensive treatment program. Ridge Zeller Therapy would like your permission to release information to your physician and other specialists working with you.

Last Name: _____ First Name: _____ Birthdate:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone (H):_____ Cell (C):_____ Preferred: Home or Cell

I, _____, authorize Ridge Zeller Therapy to release confidential information
(patient's name)

indicated by checkmark(s) below:

_____Complete records

_____ Evaluations

_____ Progress reports

_____ Confer orally with:_____

Signature:_____ Date:_____

Printed Name: _____

Release Information to Dr:	Release Information to:
Name:_____	Name:_____
Address:_____	Address:_____
City/State/Zip:_____	City/State/Zip:_____
Telephone:_____	Telephone:_____
Fax: _____	Fax: _____

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Credit Card Authorization

Questions? Contact Heather Holston, 480-365-9981, HeatherHolston@rztherapy.com

Date:_____

Patient:_____

Cardholder's Name:_____ Last four digits of your card:_____

Why is Ridge Zeller Therapy asking for a credit card?

- At this time, Ridge Zeller Therapy requests your credit card information and authorization to be placed on file for services rendered.
- Once this credit card information is entered into our secure merchant services system, it will be shredded.
- Your card will be charged your co-pay or co-insurance on a weekly basis. If you do not have insurance coverage for services rendered, your card will be charged for the service rendered on a weekly basis.
- The preauthorization will allow Ridge Zeller Therapy to collect balances due after your insurance has processed charges (if applicable).
- No charges will be applied to your credit card unless your insurance plan indicates that you are responsible for charges under the guidelines of your coverage.
- After your insurance company processes your claim for services rendered and notifies Ridge Zeller Therapy of your patient responsibility, we will notify you of the final charge and apply the charges to your card immediately, in full.
- You will receive an acknowledgement receipt confirming any charges made to your credit card.

Customer name (please print): _____

Customer signature:_____

Card number: _____

Expiration date: _____

V-Code: _____