Arizona NeuroRecovery
Treatment Innovations Center

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New Patient Form

Patient Information

Patient's Name _____ DOB _____
Last Name *First Name* *Middle Initial*

Sex: ☐ M ☐ F ☐ Hermaphrodite Age: _____

Child ☐ Adult ☐
Married ☐ Single ☐
Divorced ☐ Widowed ☐

Gender Identity: ☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Genderqueer ☐ Other ☐ Decline to Answer

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other ☐ Unknown ☐ Decline to Answer

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____

Employed? ☐ Yes ☐ No Employed by _____

Primary Care Doctor? _____

Emergency Contact _____ Phone _____

Relation to Patient _____

Primary Insurance

Name _____ DOB _____

Insurance Company _____

Group # _____ Subscriber # _____

Is the patient covered by additional insurance? ☐ Yes ☐ No ***If yes, please provide a copy.***

2812 N Norwalk, Suite 119
Mesa, AZ 85215
P: 480-621-8200 F: 480-621-8283
www.antichealth.com

Additional Patient Information

Please note that we are required by the government to ask these questions for demographic purposes.

Patient Name:_____ DOB: _____

Date: _____

Please choose a Race:

- ☐ Asian
- ☐ American Indian / Alaska Native
- ☐ Black / African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Declined

Please choose an Ethnicity:

- ☐ Hispanic / Latino
- ☐ Non-Hispanic / Latino
- ☐ Declined

What languages do you speak?

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*THIS INFORMATION IS REQUIRED FOR STATISTICAL ANALYSIS. FROM THE AGENCIES OF EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT AND BUDGET, OFFICE OF INFORMATION AND REGULATORY AFFAIRS, DUE TO REVISIONS TO THE STANDARDS FOR THE CLASSIFICATION OF FEDERAL DATA ON RACE AND ETHNICITY (10/30/1997). THE REVISED STANDARDS WILL HAVE 5 MINIMUM CATEGORIES FOR DATA ON RACE (AMERICAN INDIAN OR ALASKA NATIVE, ASIAN, BLACK OR AFRICAN AMERICAN, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, AND WHITE) AND 2 CATEGORIES FOR DATA ON ETHNICITY (HISPANIC, NOT HISPANIC). OMB IS ANNOUNCING ITS DECISION CONCERNING THE REVISION OF STATISTICAL POLICY DIRECTIVE NO. 15, RACE AND ETHNIC STANDARDS OF FEDERAL STATISTICS AND ADMINISTRATIVE REPORTING.

Assignment and Release

I, _____(patient/parent/guardian), understand that ANTIC is currently only on a cash-pay basis and is no longer taking or is contracted with insurance or GAP. But upon request, patients can be provided with a super-bill to submit to their insurer for reimbursement. The provided super-bill and any submission are the sole responsibility of the patient or parent/guardian. The patient or their parent/guardian is responsible for any charges that should arise at the time of service. If any balance on my account is over ninety (90) days past due, my account will be in default and auto-referred to a collection agency. The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower. I understand payments are accepted by credit card, check, or cash. Any checks denied for insufficient funds will incur a fee of $50.00. Initials: _____

I understand that patients or their parent/guardian may incur and are responsible for the payment of additional charges at the discretion of ANTIC, including but not limited to: (I) charges for returned checks; (II) charges for a missed appointment; (III) charges for extensive phone consultations and/or after-hours phone calls requiring treatment or prescriptions; (IV) charges for copying and distribution of patient medical records; (V) charges for extensive forms preparation or completion; or (VI) any costs associated with the collection of patient balances, all as allowed by law. In the event of a check failure, no-show, or a same-day cancellation, the patient or parent/guardian may automatically be charged $35.00. I understand that extenuating circumstances can be addressed directly with the front desk. Initials: _____

I certify that I, the patient or parent/guardian, will pay for all services rendered by Arizona Neuro-Recovery Treatment Innovations Center at the time of service. If I am unable to do so, I will make arrangements with the office in advance. This consent will end when my current treatment plan is completed or one year has passed from the date signed below

Patient/Parent/Guardian Signature_____ Date_____

Front Office and Appointment Guidelines

IN: _____ **All co-payments and account balances are due at the time services are rendered. We accept credit card, check, or cash.**

IN: _____ **You must inform the front office of any changes in address, phone number, or any other primary information. If the office has incorrect information, this could result in the rejection of insurance authorization and slower processing times.**

IN: _____ **Please give at least a 24 hour notice when canceling or rescheduling an appointment as we may use that appointment slot for another patient. There is a $35.00 fee for no-show and same-day cancellations. You may contact the front office regarding emergency situations.**

IN: _____ **Your children must be directly supervised by a parent or guardian. If this is not possible, you must bring them into the consult room with you. The front office staff is not able to supervise children as they will be occupied with their clinic duties and functions.**

IN: _____ **Walk-Ins are not permitted as this is a specialist's office, not an urgent care. In the event of an emergency, please take your child to an urgent care or their primary care physician.**

IN: _____ **Medical record request fees will vary depending on the size. For a price quote of a medical record request, please contact the front office. This fee is to cover cost of paper and/or ink cartridges.**

IN: _____ **If you are 10 minutes late or more to an in-person appointment, or 15 minutes late or more to a phone/video consult, the doctor will be unable to see you.**

IN: _____ **Please allow 24 to 48 hours for prescriptions to be filled. PRESCRIPTIONS WILL NOT BE FILLED OVER THE WEEKEND. The doctor also does not prescribe narcotics.**

Patient/Parent/Guardian Signature_____

Date_____

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HIPAA - Consent to Release Information

I, the patient, or my parent/guardian_____ hereby authorize **ANTIC** to release or discuss any and all information pertaining to myself (the patient) or my medical records with the following people.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I authorize ANTIC to contact me at:

Home #: _____ Work #:_____

May we leave a message on machine? ☐ Yes ☐ No

Cell #: _____ Alt #: _____

Signature below acknowledges you have read and understand the Privacy Notice and Patient Rights.

_____ _____

Patient/Gaurdian Signature *Date*

_____ _____

Witness Signature *Date*