AVALA®
AVALA PHYSICIAN NETWORK

PATIENT INFORMATION

Patient Name	**Home Telephone #** _____
Social Security Number	**Cell Telephone #** _____
Address	**Patient Sex**
City, State & Zip Code	**Date of Birth**
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Emergency Contact Name & Phone** **Relationship to Patient:**
Email Address (please print):	
Ethnicity of Patient: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Unknown ☐ Declined to Answer **Patient's preferred language:** ☐ English ☐ Spanish ☐ Other:	**Race of Patient:** ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Unknown ☐ Declined to answer ☐ Single ☐ Married ☐ Other
In compliance with the American Recovery and Reinvestment Act of 2009 **(ARRA)** to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.	

Financially Responsible Person (if different from above)

Full Name	Social Security Number _____
Address	Home Telephone# _____
City, State & Zip Code	Work Telephone# _____
Date of Birth	Cell Telephone# _____
Employer Name	Relationship to the patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Date Reviewed _____ Initials _____

Insurance Company Information

Primary Insurance Company Name	**Secondary Insurance Company Name**
Policy Number **Group Number**	**Policy Number** **Group Number**

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Patient Name: _____ **Date of Birth:** _____

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to AVALA, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery, and this does not relieve me of my primary obligation to pay.

Signature: _____ Date: _____

Medicare Patients

If you are covered by Medicare, please read, and sign the following:

In Medicare cases, AVALA, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, co-insurance, and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature: _____ Date: _____

Heath Information Exchange: We may share your information for treatment, payment, and healthcare operations purposes through health information exchange in which we participate for participants to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. I give consent to AVALA to share my information for treatment, payment, and healthcare operations purposes through health information exchange in which we participate for participants to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. **Initial** _____

Appointment Reminders and Other Information: We may use your protected health information to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you. For example, we may send you a newsletter about our medical practice or the medical services that we offer to patients. **Initial**_____

Photographs: We may use photography or other means of image recording to capture pictures and imaging in an effort to offer better patient identification for workforce members, security purposes and billing procedures.

Initial _____

After Hours: I understand that AVALA Care does not have an On Call physician. I understand that any message sent to AVALA Care via patient portal or voicemail left for physician after hours will not be seen until the following business day. I understand that in the event of a medical emergency after hours, I should go to the nearest emergency room. **Initial** _____

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Patient Name:_____ Date of Birth:_____

Covered Benefits: As a courtesy, we will verify and file your claim with your insurance carrier, however we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/coinsurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you or your physician elect to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for Physical Therapy services.

Co-Payments: Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks and credit cards (Visa or Master Card).

Attendance Policy: Your physician allocates a specific amount of time for your appointment to meet the needs of your rehabilitation program. We understand that there are times when you must miss an appointment, but request that you give us 24-hour notice. Please schedule a make-up appointment as soon as possible to help meet your rehabilitation goals. So that we may provide attentive care to each of our patients, please be aware that if you arrive more than 15 minutes later than your scheduled time, you may be asked to reschedule your appointment.

I have read the above statements. It is my understanding that I am financially responsible to **AVALA** for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to **AVALA**. I agree to pay the full amount of all charges incurred by the above-named patient that are not covered by my insurance provider.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. When an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance company.

_____ _____

Patient Signature Date

_____ _____

Guarantor's Signature Date

Medical Release: I hereby authorize **AVALA** to release my medical records to physicians, insurance companies, and other social agencies as necessary. I also authorize AVALA to obtain any portion of my medical record from another institution that is deemed medically necessary during my treatment. **Initial**_____

Consent to Provide Treatment: I hereby authorize **AVALA** through its appropriate personnel to perform upon me or the above-named patient appropriate physical therapy assessment and treatment procedures relating to my diagnosis. **Initial**_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices of **AVALA.**

_____ _____

Signature Date

_____ _____

Print Name Date of Birth

If not signed by the patient, please indicate relationship:

____Parent or guardian of minor patient;

____Power of Attorney, Tutrix, Curator or Designated Personal Representative

_____

(NAME OF PATIENT)

____ACKNOWLEDGMENT REFUSED:

Efforts to obtain:

_____

_____

Reason for refusal:

_____

_____