815 E. Warner Road, Suite 106
Chandler, AZ 85225
AzAdvancedTherapy@gmail.com

p. 480.963.5800
f. 480.963.5805

CLIENT INFORMATION UPDATE FORM

CLIENT'S NAME:_____

DATE OF BIRTH: _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____

RESPONSIBLE PARTY CONTACT INFORMATION:

PARENT/GUARDIAN NAME: _____

ADDRESS (if different from above):_____

CITY/STATE/ZIP: _____

PARENT/GUARDIAN EMPLOYER: _____

CELL PHONE: _____ WORK PHONE: _____

E-MAIL: _____PRIMARY CONTACT: YES ☐ NO ☐

PARENT/GUARDIAN NAME: _____

ADDRESS (if different from above):_____

CITY/STATE/ZIP: _____

PARENT/GUARDIAN EMPLOYER: _____

CELL PHONE: _____ WORK PHONE: _____

E-MAIL: _____ PRIMARY CONTACT: YES ☐ NO ☐

NAME OF PRIMARY CARE PHYSICIAN (PCP): _____

PEDIATRIC GROUP NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ FAX: _____

PRIMARY CARE PHYSICIAN E-MAIL: _____

PLEASE LIST ADDITIONAL COMMENTS OR INFORMATION THAT YOU FEEL ARE HELPFUL/IMPORTANT.

_____

_____

Date: _____

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For DES/DDD consumers with private insurance, DES/DDD requires that your private insurance company is billed prior to billing DES/DDD.

DOES THE CLIENT HAVE DDD? **YES** ☐ **NO** ☐

If yes, provide DDD Support Coordinator's Name? _____

Phone Number: _____Email:_____

PRIMARY INSURANCE:

INSURED'S NAME: _____

RELATIONSHIP: _____ BIRTHDATE: _____ SSN: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

GROUP#: _____ ID#: _____

INSURANCE COMPANY ADDRESS: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY PHONE NUMBER:_____

SECONDARY INSURANCE:

INSURED'S NAME: _____

RELATIONSHIP: _____ BIRTHDATE: _____ SSN: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

GROUP#: _____ ID#: _____

INSURANCE COMPANY ADDRESS: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY PHONE NUMBER:_____

AUTHORIZATION AND RELEASE

I authorize Arizona Advanced Therapy to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to Arizona Advanced Therapy or group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependent(s).

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **PRINTED NAME**

_____

DATE

Please provide a copy of your insurance card(s), both front and back.
Thank you for your cooperation.

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THERAPY SERVICES BILLING INFORMATION

GENERAL INFORMATION

- The front and back copies of all insurance cards must be provided prior to therapy.
- We are required to obtain prior authorization from your insurance company before therapy can begin. Therefore, it is imperative that you provide all insurance information prior to your child's first session. If your child's insurance changes in any way, you will need to provide the front and back copies of the new cards immediately. We will need to obtain prior authorization from your new insurance company prior to their next therapy session. Failure to do so may result in a denied payment by your insurance and you will be responsible for the full amount owed. ***DDD is a secondary payor and non-payment due to lack of up-to-date/current insurance information is not a denial covered by DDD.***
- If you fail to provide updated photos of the front and back of your insurance card within 7 days of your new insurance start date, and choose to continue therapy services, you will be responsible for any unpaid dates of service due to a change in insurance. In addition, these dates will NOT be covered by DDD.
- If we have your child's insurance information on file, we will bill primary insurance first. Any unpaid balances by your insurance will then be invoiced to you via Square. You may then be responsible for paying a co-payment for each therapy session, meeting your deductible, or co-insurance, depending on your insurance coverage. If we do not have your child's insurance information on file, we will invoice you by email via Square.

SQUARE

All invoices will be sent by email via Square. On the bottom of the invoice, you will find a Square Processing Fee. To avoid paying the fee, you can pay by cash or check (payable to Arizona Advanced Therapy). If you choose to pay by cash or check, you will be required to pay the full amount due minus the processing fee. Once payment is made, a receipt will be sent to you by email via Square for your records.

CLASSWALLET

If you choose to pay using ESA Funds, an invoice will be sent to you by email via Square which will include a ClassWallet processing fee. Please log into your ClassWallet account and pay the total amount due. A receipt will be sent to you via Square for your records.

DELINQUENCY

If you are unable to pay your invoice in full, please contact the office to set up a payment plan. If we do not have a payment or a payment plan in place, after 30 days, therapy will be suspended and applicable late payment fees will be applied.

30 days late: $25 additional fee
60 days late: $50 additional fee
90 days late: $100 additional fee

INSURANCE CHECKS ISSUED DIRECTLY TO INSURED

If you should receive a check from your insurance for services rendered by Arizona Advanced Therapy, it is your responsibility to turn over the funds to Arizona Advanced Therapy as soon as possible. This can be done by signing over the check or using another payment method that Arizona Advanced Therapy accepts. If you withhold the check, your therapy services will be suspended and your insurance will be notified.

I have read and fully understand the content of this Therapy Billing Services Information.

_____ _____

Parent or Legal Guardian's Signature Date

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LATE PAYMENT POLICY

A late fee will be assessed accordingly if you are more than 30 days past due on your account. ***Therapy will also be suspended until payments are made. The scheduled therapy day and time prior to suspension are not guaranteed if and when therapy services are reinstated.*** If you are unable to make a payment within this timeframe, please contact Arizona Advanced Therapy ("AAT") at 480.963.5800 to discuss a payment plan.

30 days late: $25 additional fee

60 days late: $50 additional fee

90 days late: $100 additional fee

Should a payment made to AAT by you (or someone else on behalf of you for your child's treatment) be returned for "insufficient funds" cause AAT to be charged a fee, said fee will be billed back to you and will be your responsibility to pay. The late payment policy above WILL be applied to this fee, should your account remain past due as stated above.

I have read and agree to be responsible for payment of all services.

_____
Client/Patient/Child's Name

_____ _____
Parent or Legal Guardian's Signature Date

Currently, we only accept payments via Cash, Check, or Square.

Pleasemake checks payable to Arizona Advanced Therapy.

I prefer to receive my invoices by (check one): **PAPER MAIL** ☐ **E-MAIL** ☐

Please list the preferred mailing address or email address to send invoices to below:

MAILING ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL: _____