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: _____ SEX: M / F

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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