MOORE
PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: Male / Female

Email: _____ Cell Number: _____ Home Number: _____

Referring Physician: _____ Marital Status: _____ Date of Injury: _____

Address: _____Unit #: _____ City: _____ State: ____ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone Number_____

Employer: _____ Work Phone Number: _____ SS#_____

How did you hear about us?: _____ Claim # (If Workers Comp): _____++++____

Have you had physical therapy in this calendar year? Y / N If yes, how many visits? _____

If you have Medicare, are you currently having or have you had Home Healthcare. Y / N If yes, when? _____

Have you provided us your most current insurance card(s) to be copied? Y / N

RESPONSIBLE PARTY (If the patient is not the Responsible Party)

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____Unit #: _____ City: _____ State: ____ Zip Code: _____

Home Phone Number: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Address: _____Unit #: _____ City: _____ State: ____ Zip Code: _____

HIPAA Privacy Authorization
Authorization for Use or Disclosure of Protected Health Information

I authorize Moore Physical Therapy to disclose medical information to _____, and to

_____. This information may be used by this (these) authorized person(s) in order to receive information regarding medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
This authorization covers: A) The period from:_____ To _____. OR B) Past, present, and future periods ☐

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/ Legal Guardian Signature: _____ Date: _____

HIPAA Notice Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/ Legal Guardian Signature: _____ Date: _____

List of Current Medications

Patient Name:_____

Please provide any current medications that you are taking including vitamins and supplements.

- ❑ **I am not currently taking any medications, vitamins or supplements.**

Medication Name	Dosage (mg or ml...)	Frequency (How often?)	Route of Administration (such as oral, IV, injection...)

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Missed Visit Policy

In order to provide excellent medical care to all of our patients we have developed an appointment system that sets aside time for each patient and gives us time to make adjustments when needed.

Patients who do not show, arrive late or cancel with less than a day's notice negatively affect our efforts to provide excellent care for all our patients. In an effort to reduce the number of such occurrences, we have implemented this Missed Visit Policy.

Our policy is as follows:

1. There is a $25 missed visit fee **if you do NOT give our office at least a day's notice** during business hours in the event you need to reschedule our appointment.
2. **Not showing to a scheduled appointment** without contacting us with a day's prior notice is considered a no-show and a $25.00 missed visit fee will be charged.
3. We ask you arrive a few minutes early to your appointment. If you are running late for an appointment, you need to call us to help us prepare for your late arrival. If you are **more than 15 minutes late** your visit may need to be rescheduled and a $25.00 fee assessed.

The $25 missed visit fee is your responsibility and is not covered by your insurance.

To avoid our missed visit fee, call our office during business hours -at least ONE DAY in advance for any illness, appointment changes, or cancellations.

I have read this Missed Visit Policy and by signing below I am indicating that I understand this policy.

_____ _____

Signature **Date**

Printed Name

MOORE
PHYSICAL THERAPY

ACCIDENT INFORMATION
(Fill out for Personal Injury claims)

Insurance: _____ Insured Name(s):_____ Claim Number: _____

Insurance Address: _____City: _____State: ____ Zip Code: _____

Contact Name: _____Phone Number: _____ Extension: _____

Attorney's Name: _____ Phone Number: _____

Date of Accident: _____

Personal Injury Payment/Billing Determination Form

It is Moore Physical Therapy's policy to have you choose now at the onset of care to either bill your health insurance (collecting all deductibles, co-insurance, and/or co-payments at time of service) or sacrifice timely payment and wait as required for payment until the claim settles.

Initial either option 1 or 2 below to indicate your decision regarding billing your insurance or waiting for the claim to settle.

___ Option 1. I would like Moore Physical Therapy to bill my health insurance. I understand that I am responsible to pay at time of service for all deductibles, co-insurance, and co-payments.

___ Option 2. I would like Moore Physical Therapy to wait for payment until the claim settles, not billing my health insurance.

Liens are filed on all motor vehicle accidents and injury liability claims.
I understand that I am ultimately responsible for payment in full on my account.

_____ _____
Patient/Legal Guardian Date