MOORE
PHYSICAL THERAPY

CLINIC:

APPOINTMENT

DIAGNOSIS / Rx DATE

PATIENT INFORMATION
PLEASE PRINT

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

Email: _____ Cell Number: _____ Home Number: _____

Referring Physician: _____ Physician Phone Number: _____

Social Security Number: _____ Marital Status: _____ Date of Injury: _____

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

Emergency Contact: _____ Relationship: _____ Phone Number_____

Employer: _____ Work Phone Number: _____

Who referred you to our clinic: _____ Claim Number (If WC): _____

Have you had physical therapy in the last twelve months? Y / N If yes, when? _____

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

RESPONSIBLE PARTY

Name: _____ Date of Birth: _____ Relationship: _____

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

SSN: _____ Home Phone Number: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

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

INSURANCE INFORMATION

Primary Insurance company: _____ Phone Number: _____

Group Number: _____ Member Identification Number: _____

Policy Holder's Name: _____ Phone Number: _____

Relation to Patient: _____ Date of Birth: _____ Social Security Number: _____

Secondary Insurance Company: _____ Phone Number: _____

Group Number: _____ Member Identification Number: _____

Policy Holder's Name: _____ Phone Number: _____

Relation to Patient: _____ Date of Birth: _____ Social Security Number: _____

AUTO ACCIDENT INFORMATION

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

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

Contact Name: _____Phone Number: _____ Extension: _____

Attorney's Name: _____ Phone Number: _____

MOORE
PHYSICAL THERAPY

Welcome to **Moore Physical Therapy**

It is our desire to promote your healing and maximize your physical abilities. We will instruct you in methods which will hasten your recovery and help you to avoid future injury. Our aim is to provide a safe, comfortable, and professional environment that exceeds your treatment expectations.

We will expect you to take an active part in accomplishing short-term and long-term goals. It is extremely important that you keep each of your appointments and follow the instructions you will receive from your therapist. **Please call us 24 hours in advance if you must cancel or reschedule your appointment. If you miss your appointment without notice or cancel with less than 24 hours notice you may be subject to a cancellation fee of $25.**

Assignment of Benefits/Authorization to release medical

I do hereby consent to such treatment by the authorized personnel of Moore Physical Therapy as may be dictated by prudent medical practice for my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

I, the undersigned or designated representative for the patient, do hereby assign all medical benefits of which I am entitled to Moore Physical Therapy. I understand that I am ultimately responsible for payment in full on my account, not the insurance company. I understand that Moore Physical Therapy files health insurance claims as a courtesy to their patients. I recognize that Moore Physical Therapy can only make estimates regarding my insurance benefits based on the information provided by myself and the insurance company. In the event my insurance company does not pay as much as expected, the remaining balance is due and payable immediately by myself.

DELINQUENT ACCOUNTS/ COLLECTION PROCEEDINGS
All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates. In the event my account is turned over to a collection agency for non-payment or other delinquency, I will be responsible for payment of any collection costs (up to 43%) and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and I will be responsible for payment of regular fee for procedures at the time of service.

I do hereby authorize Moore Physical Therapy to release all information necessary to secure the payment of said benefits.

_____ _____
Patient/Legal Guardian Date

Notice of Privacy Practices: Acknowledgment

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

_____ _____
Patient/Legal Guardian Date

Thank you for allowing Moore Physical Therapy the opportunity to serve you. If you have questions regarding the above information please ask for assistance.

We Care About Your Privacy

MOORE PHYSICAL THERAPY
2500 S. Power Rd.Ste; 123 Mesa, AZ 85209' (480)218-1344

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice. **We Have the Right to:**

4. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
5. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: 1. Before we make an important change in our pri vacy practices, we will change this notice and make] the new notice available upon request.

•These privacy practices are currenDy in effect and *v*'*/* remain in effect until further notes.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you. Additional Uses and Disclosures: In addition to using and disclosing your medical Information for treatment, payment, and healthcare operations, we may use and disclose medical information for the following purposes.

Notification:We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you

are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Selling patient information: We will not sell your medical information without your authorization. Additionally, any other use or disclosure of your information not described in this notice will be made only with your authorization.

Paying out of pocket in full: You have the right to restrict disclosures of your personal health information to health plans where you pay out of pocket in full for healthcare services.

Breaches of unsecured information: You have the right to know if there has been an impermissible use of your medical information. Notification will occur within 60 days of the discovery of the breach.

Electronic records:If you request an electronic copy of your personal health information that is maintained electronically, then we

must provide access in the electronic format you request if it is readily producible. A hard copy is acceptable if you are unable to receive the information in the electronic format that we are able to provide you. If you request we send the information via unencrypted email be advised that you assume the risk of the unsecured method of delivery. We are not required to have encrypted email services.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders, Judicial and Administrative Proceedings:

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited informa tion with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administra tive, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request rf we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer. If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer

or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.