MOORE
PHYSICAL THERAPY

PATIENT INFORMATION

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

Email: _____ Cell Number: _____ Home Number: _____

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

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

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? _____

Have you lived in a Healthcare facility and/or had Home Healthcare. Y / N If yes, when did you last? _____

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

RESPONSIBLE PARTY or SECOND HOME ADDRESS
Fill in applicable information below if the patient is not the responsible party or has a second home address

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 the period from: A. _____ To _____. OR B. All 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 Acknowledgement

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

Patient/ Legal Guardian Signature: _____ Date: _____

MOORE
PHYSICAL THERAPY

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 miss their scheduled appointment, arrive late or cancel with less than a day's notice negatively affect our efforts to provide excellent care for all of 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. A $25 fee may be assessed if you **do NOT give our office at least a day's notice** during business hours in the event you need to reschedule your appointment.
2. **Missing a scheduled appointment** without contacting us with the aforementioned notice is considered a "no-show" and a $25.00 missed visit fee may be assessed.
3. We ask you to arrive a few minutes early to your appointment. If you are running late for an appointment, please call to help us prepare for your late arrival. If you are **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 BUSINESS 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 only for Personal Injury claims)

Insured Name(s):_____ Claim Number: _____

Insurance Company: _____

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

Contact Name: _____Phone Number: _____ Extension: _____

Attorney's Name: _____ Phone Number: _____

Date of Accident: _____

Personal Injury Payment/Billing Determination Election

It is Moore Physical Therapy's policy that you choose now at the onset of care between 1) billing your health insurance which will require you to pay all deductibles, co-insurance, and/or co-payments at time of service; or 2) take out a lien on the liable accident insurance(s) and wait to pay any out-of-pocket payments until the claim settles.

Initial the option you choose below to indicate your decision below.

_____ **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 motor vehicle accidents and injury liability claims. A $60 Maricopa County recording fee will be added to your account and will be collected prior to the release of the lien at settlement.

I sign below and understand that I am ultimately responsible for payment in full on my account.

_____ _____
Patient/Legal Guardian Date

MOORE
PHYSICAL THERAPY

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...)

MOORE
PHYSICAL THERAPY

Health problems may affect your treatment. Please check (x) any of the following that apply to you:

- ☐ Arthritis (Rheumatoid / Osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive
- ☐ Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS), or Emphysema
- ☐ Angina
- ☐ Congestive Heart Failure (or Heart Disease)
- ☐ Heart Attack (Myocardial Infarction)
- ☐ High Blood Pressure
- ☐ Neurological Disease (Such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I And II
- ☐ Gastrointestinal Disease (Ulcer, Hernia, Reflux, Bowel, Liver, Gall Bladder)
- ☐ Pacemaker
- ☐ Seizures
- ☐ Visual Impairment
- ☐ Hearing Impairment (Very Hard of Hearing, Even with Hearing Aids)
- ☐ Back Pain (Neck Pain, Low Back Pain, Degenerative Disc Disease, Spinal Stenosis)
- ☐ Kidney, Bladder, Prostate, or Urination Problems
- ☐ Previous Accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Hepatitis, Tuberculosis, HIV, AIDS, or Other Bloodborne Condition
- ☐ Prior Surgery
- ☐ Prosthesis / Implants
- ☐ Sleep Dysfunction
- ☐ Cancer
- ☐ None of the Above

Height (Required): _____ ft. _____ in. Weight (Required): _____

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐

MOORE
PHYSICAL THERAPY

Within the last 12 months:		
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO