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: _____

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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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Consent for Purposes of Treatment, Payment, and Health Care Operations

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 except in acts of negligence.

I, the undersigned or designated representative for the patient, do hereby assign all applicable medical benefits to which I am entitled to Moore Physical Therapy. I understand that I am ultimately responsible for payment in full on my account, not my insurance company. **I understand that Moore Physical Therapy verifies coverage and 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 the insurance company and myself**. Moore Physical Therapy encourages all patients to call their insurance company to understand their Insurance benefits. I understand that said estimates may result in an over or underpayment of my responsibility. I understand that any unpaid balance remaining is my responsibility to pay immediately upon notification. I also understand that I will receive a refund for any overpayment at the end of treatment when all claims have been processed and paid. I also understand that I have the option to choose not to bill insurance and pay out of pocket instead.

DELINQUENT ACCOUNTS/ COLLECTION PROCEEDINGS
All delinquent accounts (30 days or older) are subject to a $30 per month late fee 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 including late fees. 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 fees 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.

I understand Moore Physical Therapy uses a variety of electronic communications methods including phone, text messages, or e-mail to communicate with me for the limited purposes of appointments, available services, and other healthcare related communications. I authorize Moore Physical Therapy to disclose limited protected health information to other persons who may answer my electronic communications such as phone, text messages, or email.

My signature below indicates that I have read and understand and consent to the above information.

_____
Print Name

_____ _____
Patient/Legal Guardian Signature Date

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Missed Visit Policy

Our scheduling method sets aside time for each patient to receive the care they need.

We have established this policy in order to avoid conflicts in caring for all of our patients. Our aim is to prevent cancellations with less than a day's notice, missed scheduled appointments, or late arrivals.

Our policy is as follows:

1. We require that you provide us with **at least a day's notice during business hours** when canceling an appointment. We know the unexpected happens and appreciate you letting us know the circumstances. With repeated violations of this policy you may be placed on a "call same day" status which will require you to call in on the day you wish to be seen and choose from the currently available appointments.

2. A **"No-Show"** is missing your appointment without notifying us. If this occurs you may be placed on a "call same day" status requiring you to call on the day you wish to be seen and choose between the currently available appointments.

3. Please arrive **five minutes early** for your appointment. If you are **late to your scheduled appointment time** your visit may need to be rescheduled and the appointment may be considered as a violation of item 1 above. If you are running late for an appointment, please call to help us prepare for your late arrival.

4. Note: If you are placed on a "call same day" status, you can be restored to the normal scheduling method after one successful "call same day" appointment.

Thank you for helping us set aside time for each patient in need.

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

_____ _____

Signature **Date**

_____

Printed Name