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

Missed Visit Policy

At Moore Physical Therapy, we set aside special time just for you so you can receive the care and attention you deserve. When appointments are missed or canceled without notice, it can make it difficult for us to serve other patients who may be waiting for that time.

This policy is designed with kindness and fairness in mind, to help ensure every patient has the opportunity to receive care when they need it most.

Cancellations (with less than one business day's notice)

- **First occurrence** – You'll receive a reminder of the importance of providing at least 24 hours' notice. We will let you know that a $50 fee will apply if another late cancellation occurs within the next 30 days.
- **Second or more occurrences (within 30 days)** – A $50 fee will be charged. (This fee cannot be billed to insurance or third-party payers.)
- **Policy reset** – If no late cancellations occur within 30 days, your record resets as if no prior cancellations happened.

If you believe your situation may require more frequent changes or cancellations, please let us know. Together, we can set up a plan that works for you—such as a **"same-day call status"** option for scheduling.

No-Shows (missed appointment without notice)

- **First occurrence** – A $50 fee will be charged. (Not covered by insurance or third-party payers.)
- **Second or more occurrences** – A $50 fee will be charged, and scheduling will move to a **"same-day call status"** to help ensure appointment availability.

Arriving On Time and Rescheduling

Please plan to arrive **5 minutes early** for your appointment. If you are late, we may need to reschedule, and the visit could be considered a "no-show" under the policy above. If you know you'll be running late, a quick call helps us prepare and do our best to still see you. **Rescheduling** the missed visit to be seen within 24 hours may avoid incurring the $50 fee.

Acknowledgment
I have read and understand this Missed Visit Policy. By signing below, I agree to the terms listed.

Patient or Guardian Signature: _____Date_____

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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: _____ State in which accident occured_____

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 all motor vehicle accidents and injury liability claims and a $60 fee will be added to file and release the lien.

I understand that I am ultimately responsible for payment in full on my account which includes contacting Moore PT and paying my physical therapy account balance in the case that I receive payment directly from the insurance company once settlement is reached.

_____ _____
Patient/Legal Guardian Date