

Patient Demographics (Medicare)



MOYE
PHYSICAL THERAPY

Name: _____

Date of Birth: _____

Street Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

SSN: _____ or Drivers License # _____

Emergency Contact name: _____ Phone #: _____

INSURANCE

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Have you received any Home Health services in the past 30 days? ☐ Yes ☐ No

If Yes, Have you been discharged from home health? ☐ Yes ☐ No Discharge Date: _____

Medicare does NOT pay for Outpatient Physical Therapy if you are currently receiving Home Health services and/or have not been discharged from Home Health

Have you received outpatient physical or speech therapy this calendar year? ☐ Yes ☐ No

Medicare allows \$2040 per calendar year for physical therapy and speech therapy services combined

Check ANY answers that best explain the cause of your current symptoms:

CASE INFO

☐ Fall ☐ Abuse ☐ Sports Injury ☐ Another Party Responsible ☐ Other Accident ☐ Unknown

☐ Auto Accident — What State where you in? _____ Are you: ☐ At Fault ☐ No Fault

☐ Job Injury— Is this a Work Comp Claim? ☐ Yes ☐ No (If So Please Provide Employer's Information)

Employers Name _____ Phone # _____

When are you scheduled to return to your physician that referred you? _____

HIPPA RELEASE

Please list any family members or other individuals that we may discuss your case with:

PATIENT AGREEMENT

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Moye Physical Therapy** to furnish medical care and treatment to _____ (Patient Name) considered necessary and proper in diagnosing or treating his or/her physical and/or mental condition.

BENEFIT ASSIGNMENT

I, the undersigned, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to entities doing business as **Moye Physical Therapy**. A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL POLICY

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Moye Physical Therapy**.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for the services rendered to you.

I, the undersigned, understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Jeff Moye Inc. dba Moye Physical Therapy has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
 - a) texting cell phone
 - b) e-mail
 - c) voice message to primary phone number
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

Estimated Insurance Benefits are: (Not a guarantee of payment)

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative

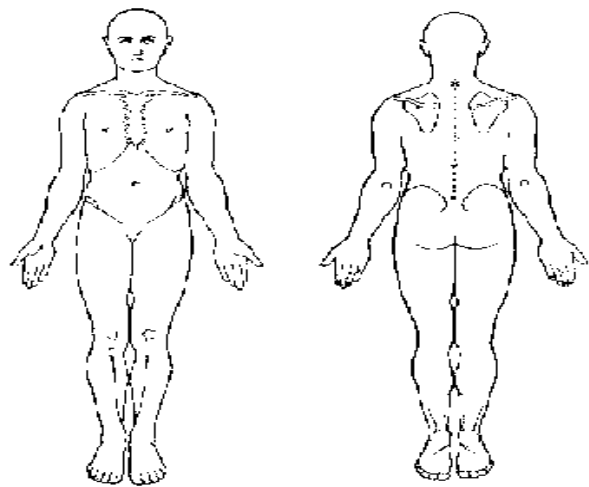
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed : _____ Witness: _____

Name _____

1) Mark the location of your symptoms on the body chart.

Pain X
Numbness ~~~~~
Weakness O



2) Within the last week, how would you **rate your pain 0-10** with 0 pain and 10 being the worst pain imaginable? being no

At best: _____ Currently _____ At worst: _____

3) What was the date of your injury or onset of symptoms? _____

4) What tests have been performed (ie. MRI, EMG,X-rays, etc...)? _____

5) If you have not provided a list of all medications, please list them below:

6) Past Medical History: Please check any of the following conditions that apply to you.

Medication	Dosage Medicare Only

Medication	Dosage Medicare Only

- ___ Heart Problems
- ___ Kidney Problems
- ___ Liver Problems
- ___ Artery or Vein Problems
- ___ Urinary Problems/Infections
- ___ Asthma / Breathing Problems
- ___ Cancer
- ___ Diabetes
- ___ Stroke
- ___ Easy Bruising/Bleeding

- ___ Sleeping Problems
- ___ Back/Neck Injury
- ___ Balance Problems
- ___ Headaches
- ___ Pinched Nerve
- ___ Blurred Vision
- ___ Dizziness
- ___ Rheumatoid Arthritis
- ___ Lupus
- ___ Osteoarthritis

- ___ Hepatitis
- ___ Tuberculosis
- ___ HIV
- ___ Osteoporosis
- ___ Bone Fracture
- ___ **Currently Pregnant**
- ___ Allergies (specify)
- _____
- _____
- _____

7) List any problems or

other medical surgeries you have had in the past.