Patient Demographics

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**: _____

If Patient is not the Primary Policy holder—please fill out the information below:

Name of Policy Holder: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____ Phone #: _____

Secondary Insurance: _____ **Member ID**: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____ Phone #: _____

Have you received Physical Therapy or seen a Chiropractor this year? ☐ Yes ☐ No

If Yes - How many visits did you attend? _____

CASE INFO

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

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

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

If you have an attorney, who is the attorney representing your case? _____

☐ 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 anyone that we can 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 is 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: _____

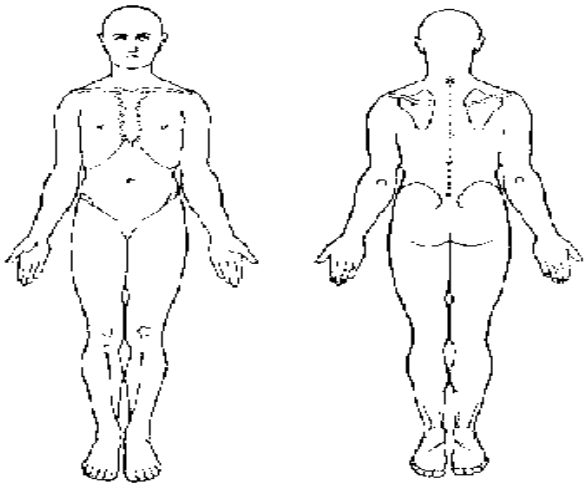
Name_____

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 being no pain and 10 being the worst pain imaginable?

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**

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____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.

_____

_____

_____