

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 # _____

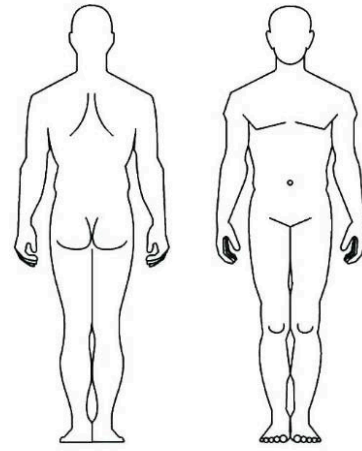
When are you scheduled to return to your physician that referred you? _____

HIPPA RELEASE

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

Mark the Location of your symptoms on the body chart using these symbols:

- X = Pain
- O = Weakness
- W = Numbness



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: _____

What was the date of your injury or when did your symptoms begin? _____

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

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

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

- | | | | |
|---------------------------|-----------------------------|------------------|---------------|
| Heart Problems | Artery or Vein Problems | Cancer | HIV |
| Kidney Problems | Urinary Problems/Infections | Diabetes | Lupus |
| Liver Problems | Asthma/Breathing Problems | Back/Neck Injury | Stroke |
| Headaches | Blurred Vision | Dizziness | Pinched Nerve |
| Rheumatoid Arthritis | Sleeping Problems | Osteoarthritis | Hepatitis |
| Tuberculosis | Easing Bruising/Bleeding | Osteoporosis | Bone Fracture |
| Currently Pregnant | Allergies (specify): _____ | | |

List Any other medical problems, or surgeries you have had in the past:

Patient Agreement

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

I, the undersigned, hereby state that by signing this consent, I acknowledge and agree as follows:

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 disclosure 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.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

TEXT AND EMAIL: Text messaging or email do not meet the security standards required, by law, to communicate healthcare information without the patient's or legal guardian's consent. Due to the high demand for communication convenience by our patients, Moye physical therapy offers limited communication via text and email for the following items:

- Appointment notifications: These may include appointment reminders, notifications necessary for scheduling, or notifications regarding missed appointments.
- Billing statements
- In response to your specific request for health information through text or email. If you text or email a request for health information, it shall be considered as consent to respond using the same mode of communication (unless you specify otherwise). Responses shall include only the specific information you are requesting.

You may opt out of receiving any text or email communications (at any time) by signing our text and email Opt-Out form or by indicated "Do not text or email" below. This will be made available to you, upon request, by the front desk attendant. Your signature below shall indicate you give Moye Physical Therapy permission to use text and email under the conditions described in this section, unless you opt out as described above.

Do not text or email (by selecting this option, you will not receive appointment reminders or other communication.)

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.

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.

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

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 as is considered necessary and proper in diagnosing or treating his/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 will 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.

PRINT NAME _____

SIGNATURE _____

DATE _____

Optimal

Instructions: Please circle the level of difficulty that you have for each activity today.	Able to do without any difficulty	Able to do With little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling Over	1	2	3	4	5	9
3. Moving - lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/Stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking-short distance	1	2	3	4	5	9
11. Walking-long distance	1	2	3	4	5	9
12. Walking-outdoors	1	2	3	4	5	9
13. Climbing Stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

Patient Name

Date