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 #: _____

Was there another reason why you chose our office, *OTHER* than your Doctor's Office ? **Referral Source**

Friend or Family Recommended Road Sign Ad or Brochure Social Media Internet Search

Insurance Recommendation Other:_____ No, My Dr's Office recommended

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 #: _____

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

If Yes - How many visits did you attend? _____

(Some insurance policies have a visit limit—if that limit is exceeded, they will not cover additional visits)

CASE INFO

Check ANY answers that best explains 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? _____

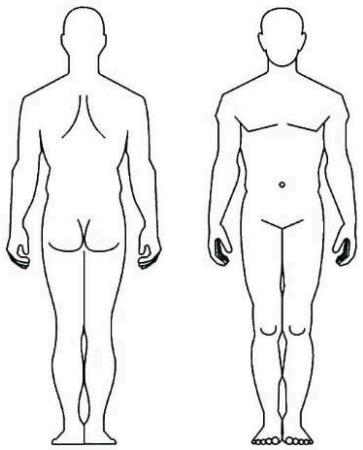
HIPPA RELEASE

Please list anyone that we can discuss your case with: _____

_____

_____

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



X = Pain

O = Weakness

≈ = 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 circle 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 PROTESTED HEALTH INFORMATION

I, the undersigned, hereby state 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 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 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. **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.)

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 therestriction 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.

8understand 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 PhysicalTherapy. 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_____