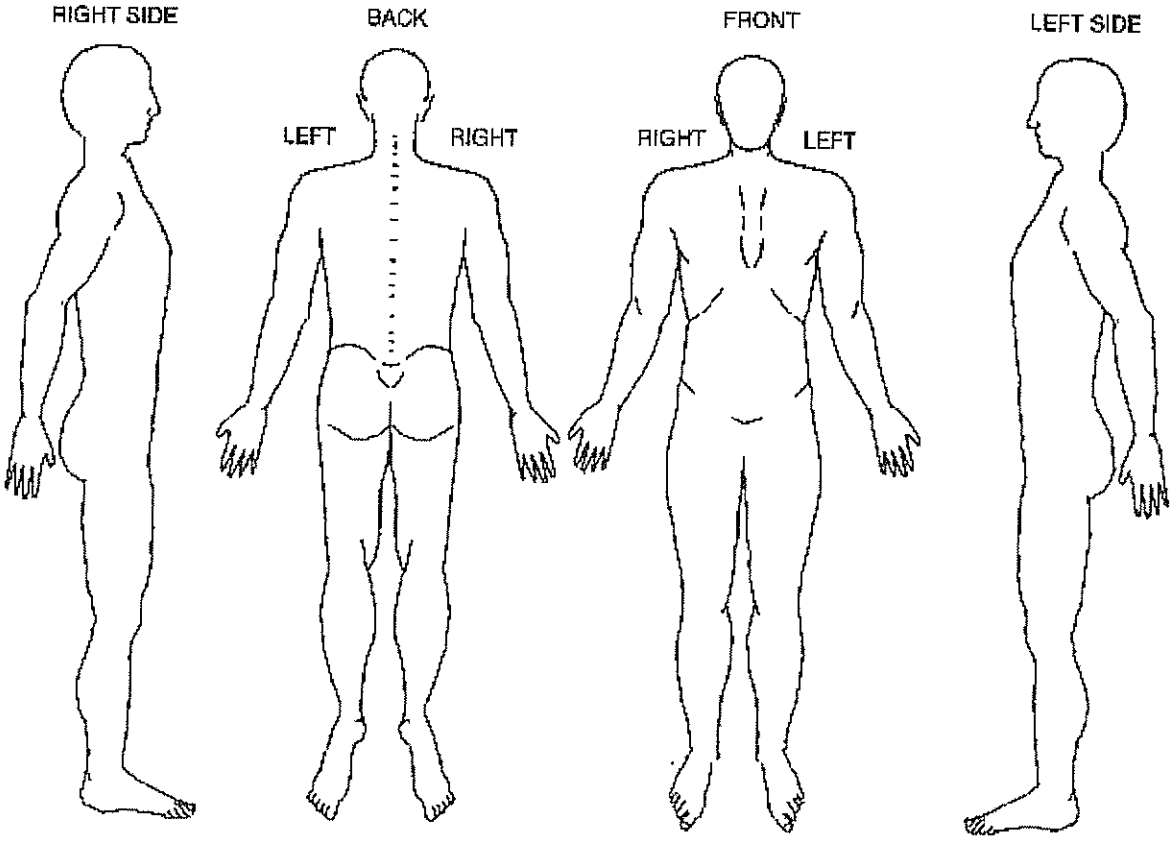
Moreland Physical Therapy

Name:_____ **Date:** _____

On the diagram below, please indicate where you are currently experiencing pain or other symptoms:



Please circle a number indication your symptom level for each of the following categories:
(0=no pain or symptoms, 10= the worst pain/symptoms you have had)

Currently (while you are filling this out)

0 1 2 3 4 5 6 7 8 9 10

The BEST (smallest or least painful) your symptoms have felt in the past 24 hours

0 1 2 3 4 5 6 7 8 9 10

The WORST (largest or most painful) your symptoms have felt in the past 24 hours

0 1 2 3 4 5 6 7 8 9 10

CONFIDENTIAL MEDICAL INFORMATION

Please state current problem(s) _____ Date of onset _____

Are you currently being treated by a chiropractor _____ or home health agency _____?

Have you had physical therapy somewhere else within the last year? YES NO

If so, where: _____ and when: _____

Current Height _____ Current Weight _____

Medical History – Check if you currently have or previously had any of the following:

____ Arthritis	**____ Seizures**	**____ MERSA/ staph infection**
____ Asthma	**____ Stroke/TIA**	**____ Ulcers**
____ Hepatitis	**_____Gout**	**____ Chronic fatigue / Fibromyalgia**
____ Thyroid Problems	**_____Osteoporosis**	**____ Cancer (Location _____)**
____ Vascular Disease	**_____ Diabetes**	**____ Neurological Disorder**
____ Anxiety	**_____Pregnant**	**____ High blood pressure**

____ Heart Problems (____pacemaker, ____congestive heart failure, ____heart attack)

Major Surgeries _____

Allergies_____

Any falls in the last 12 months _____ Injury from the fall?_____

List of Current Medications_____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature: _____ Date: _____

(Patient/Guardian)

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Social Security: _____ Martial Status: _____ Sex: M or F
Home Address: _____ City_____State_____Zip Code_____
Mailing (if different) _____Home Phone #:_____Cell #: _____
Employer Name _____
Occupation: _____ Office Phone #:_____
Email Address: _____

Emergency Notification

Name: _____ Relationship: _____Phone #:_____

Physician Information

Referring Physician:_____ Primary Care Physician: _____

Primary Insurance Information

Policy Name: _____Policy # _____ Group #_____ Plan Type_____
Policy Holder Name: _____RELATION TO PATIENT_____
Social Security #: _____Date of Birth: _____ Age: _____ Sex: M or F
Marital Status: _____Home Phone #:_____ Cell #:_____
Home Address: _____ City _____ State _____Zip Code_____

Secondary Insurance Information

Policy Name: _____Policy # _____ Group #_____ Plan Type_____
Policy Holder Name:_____RELATION TO PATIENT_____
Social Security #:_____Date of Birth:_____

Workers Compensation

Insurance Company _____Claim #_____ Date of Injury_____
Case Manager_____Phone #_____Fax #_____
Employer at time of injury_____State_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits (Medicare, private insurance, major medical benefits, worker's compensation and other health plans) to Moreland Physical Therapy. A photocopy of the assignment is to be considered as valid as the original. I hereby authorize Moreland Physical Therapy to release all medical information and records necessary to secure payment for services rendered.

Signature: _____ Date: _____
(Patient/Guardian)

PATIENT PRIVACY POLICY AND PROCEDURES STATEMENT

Dear Patient,

Moreland Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide healthcare treatment, payment, and daily operations of the facility. Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 775-359-1199.

Moreland Physical Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature_____Date _____

(Patient/Guardian)

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give by consent for Moreland Physical Therapy to furnish medical care and treatment, which is considered necessary and proper in the diagnosing or treating of my physical condition.

Signature_____Date _____

(Patient/Guardian)

FINANCIAL POLICY STATEMENT/RESPONSIBILITY AGREEMENT

Our policy is to bill your insurance carrier or the provider of medical benefits as a courtesy to you; you are responsible for the entire bill when the services are rendered. Required copayments and estimated coinsurances are to be made as services are rendered and arrangements are to be made for payments not covered by your medical benefits or estimated coinsurances as soon as those amounts are known.

I hereby authorize my insurance company to pay the proceeds of any benefits due me directly to Moreland Physical Therapy. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the case.

Please read and initial:

____ If any portion is not paid by my insurance, I agree to make arrangements for prompt payment of the bill in full (within 60 days).

____Co-payments are due at time of visit unless prior arrangements are made. All co-insurance percentages paid at the time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

____ If any *payments of medical benefits that are made directly to you* for services rendered by Moreland Physical Therapy, you must promptly remit such payment directly to Moreland Physical Therapy.

____ Unless prior arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

____There is a fee of $25.00 for any checks returned by the bank.

____ If you do not show up for an appointment or cancel with less than 24 hours notice you will be charged $30.00. This fee must be paid before a new appointment will be scheduled. If you have two No Calls/No Shows, future scheduled appointments will be removed from the schedule.

____Workers compensation cases require written approval/authorization by your employer and/or Work Comp carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

____If you fail to make payments for which you are responsible, your account may be assigned to a collection agency.

____If your account is assigned to a collection agency, they will charge a commission/fee that may be as much as 50% of the amount you owe to Moreland Physical Therapy. We may add this additional commission/fee to the amount you owe Moreland Physical Therapy, and you agree to pay the additional amount.

____The additional amount of a collection agency's fee or commission to your unpaid balance may result in you owing a sum in excess of the amount owed. For example, if your unpaid balance owed is $1,000.00, Moreland Physical Therapy may add up to $500.00 to your account and you agree to pay the sum of $1,500.00 in such an event.

____You understand and agree that in the event legal action is commenced to enforce your obligation hereunder, that you will pay court costs and reasonable attorney's fees.

I have read and understood the above information and/or it has been explained to me. I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature:_____*(Patient/Guardian)* Date: _____

Witness:_____ Date:_____