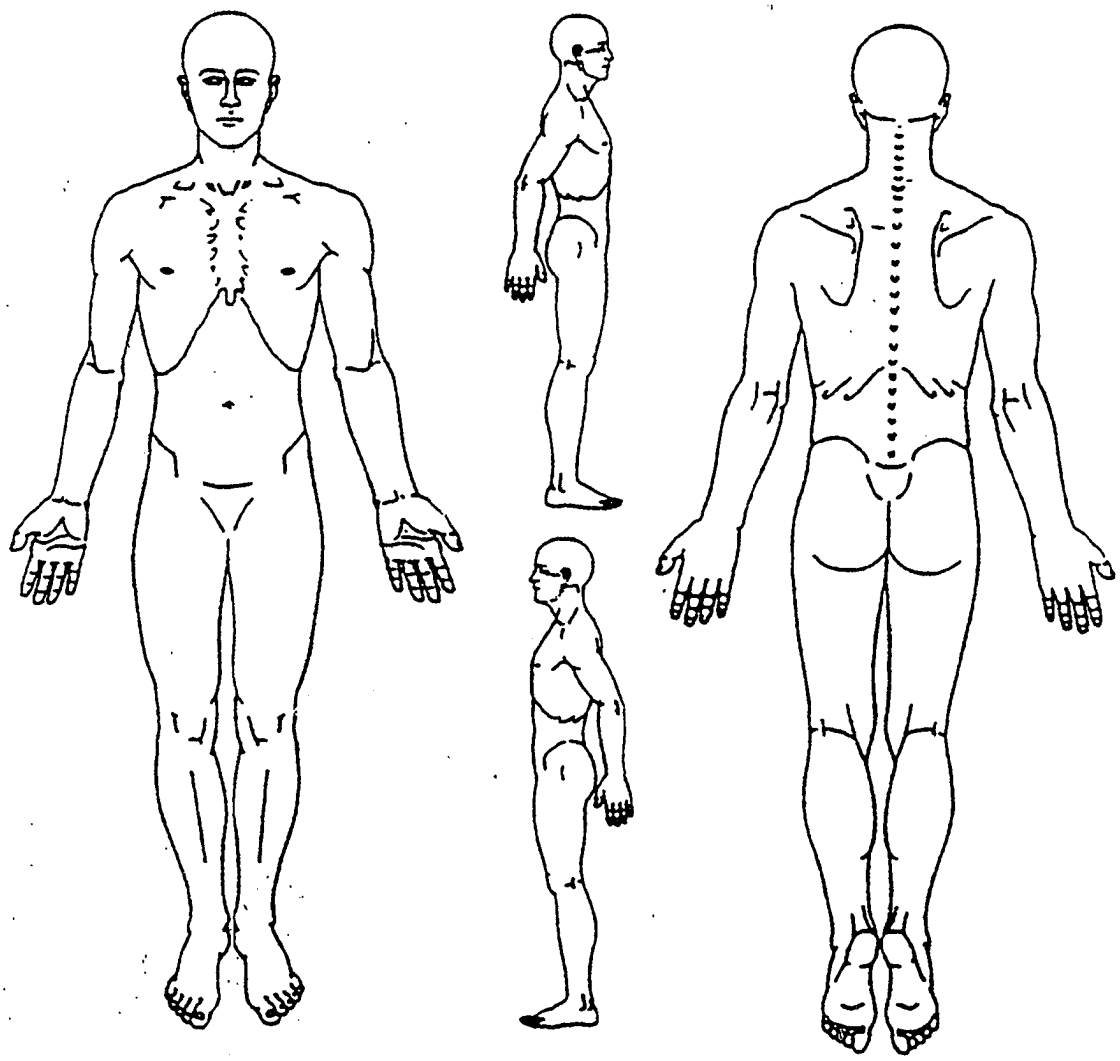
Moreland Physical Therapy

NAME: _____ DATE: _____

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



Please circle a number indicating your symptom level for each of the following categories:
(0 = no pain or symptoms, 10 is 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

Moreland Physical Therapy

PATIENT PRIVACY POLICY & PROCEDURES STATEMENT

Dear Patient,

Moreland Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 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 health care 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)

Moreland Physical Therapy

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Date of Birth : _____
Social Security #: _____ Sex: M or F
Marital Status: _____ Home Phone # _____ Cell # _____
Home Address: _____ City _____ State _____
Zip Code : _____ Mailing (if different) _____
Employer Name and Address _____
_____
Occupation: _____ Office Phone # _____
Email Address : _____

Emergency Notification
Name : _____ Relationship: _____ Phone #: _____

Physician Information
Referring physician : _____ Primary care physician : _____

Primary Insurance Information

Policy Name	Policy #	Group #	Phone #	Plan Type

Policy Holder Name : _____
Relationship to patient: SELF PARENT SPOUSE GUARDIAN OTHER
Social Security # : _____ Date of Birth : _____ Age: _____ Sex: M / F
Marital Status : _____ Home Phone # : _____ Cell # _____
Home Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

Secondary Insurance Information

Policy Name	Policy #	Group #	Phone #	Plan Type

Workers Compensation
Insurance Company _____ Date of Injury _____
Claim # _____ Case Manager : _____
Phone #: _____ Fax # _____
Employer at time of injury _____ State _____

CONSENT FOR CARE AND TREATMENT

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

Signature : _____ Date:_____
(Patient/Guardian)

Moreland Physical Therapy

CONFIDENTIAL MEDICAL INFORMATION

Please state current problem(s) _____Date of onset _____

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

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	__ Chronic fatigue / Fibromyalgia
__ Other breathing problems	__ Ulcers	__ Hepatitis
__ Thyroid problems	__ Gout	__ Cancer (location _____)
__ Vascular disease	__ Osteoporosis	__ Neurological disorder
__ Diabetes	__ Anxiety	__ High blood pressure

__ Heart problems (__ pacemaker, __ congesitive heart failure __ heart attack)

__ Pregnant

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)

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 this 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)

Moreland Physical Therapy

FINANCIAL POLICY STATEMENT/RESPONSIBILITY AGREEMENT

It is the policy to bill your insurance carrier or the provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances 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 also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in the case.

Please read and initial:

Payments:

_____ 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

_____Co-payments are due at time of visit unless prior arrangements are made. All co-insurance percentages paid at 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.

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

Missed appointment Fee:

_____ If you do not show up for an appointment or cancel with less then 24 hrs notice you will be charged a **$30.00** fee. 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

Returned Checks:

_____ There is a fee of **$25.00** for any checks returned by the bank

Workers Compensation:

_____ 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.**

Unpaid Bills/Collection Agency:

_____ If you fail to make timely payment for any amount for which you are responsible, your account may be assigned to a collection agency for collection.

_____ If your account is assigned to a collection agency, the collection agency will charge a commission or fee that may be as much as 50% of the amount you owe to Moreland Physical Therapy. You agree that if the account is assigned to a collection agency, Moreland Physical Therapy may add the amount of the collection agency commission or 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 substantially in excess of the amount owed for medical services. For example, if your unpaid balance owed to Moreland Physical Therapy is **$1000.00**, Moreland Physical Therapy may add up to **$500.00** to your account and you agree to pay the sum of **$1500.00** 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 and 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:** _____