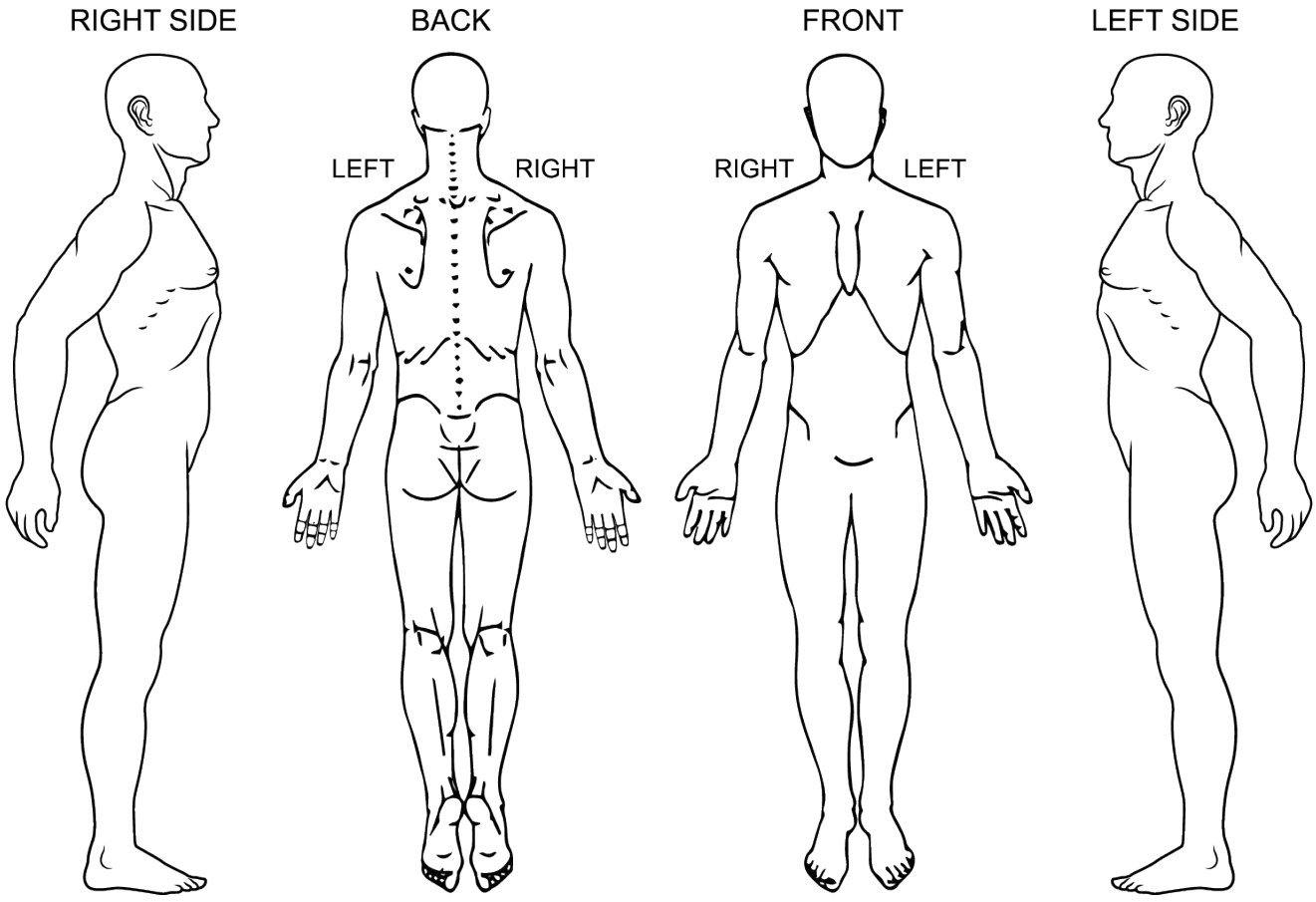
Moreland Physical Therapy
& Sports Rehabilitation Center

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

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Policy for Cancellations and No Shows
REQUIRED BY ALL PATIENTS

Missed or late cancelled appointments without a 24-hour notice will result in a **$80 No-Show Fee. 2 consecutive or 3 total No-Shows may result in the immediate discharge of your case at the discretion of the Therapist**. This fee is a separate charge that will **NOT** be covered by your insurance plan. You will need to pay the fee in full before you reschedule any future appointments.

Please understand that when you No-Show, three people are affected:

1. The Patient because you do not get the treatment prescribed by the doctor.
2. The Therapist who now has a space in their schedule, time was reserved for you personally. **OUR THERAPISTS DO NOT GET PAID IF YOU DO NOT SHOW UP**.
3. Another patient could have been scheduled for treatment if there had been proper notice.

I agree to pay Moreland Physical Therapy no-show fees as stated above if I no-show or have not called Moreland Physical Therapy at least 24 hours in advance to cancel my appointment.

Patient Signature: _____ Date: _____

Moreland Physical Therapy requires a debit/credit card or health savings account and signature on file as a method of payment **ONLY FOR NO-SHOW FEES**. The card you provided us will be charged **ONLY** if there is a no-show fee on your account. **Deductibles, co-insurance, co-pays, and any other payments will NOT be charged on your debit/credit card unless otherwise requested by you, the patient.** A receipt can be sent to your address upon request. I agree not to dispute the payment with my credit card company, so long as the transaction corresponds to the terms of Moreland Physical Therapy.

Copy of Card Provided Upon Arrival ____ Billing Zip code for card provided: _____

OR

Patient Name (Print): _____

Amex/MC/Visa/Discover Card Number: _____

Expiration Date: _____ CCV#: _____ ZIP: _____

Patient Signature: _____ Date: _____

This notice/signature serves as your consent to charge the card listed above for No-Show Fees ONLY. Under no circumstance other than the conditions mentioned above will Moreland Physical Therapy charge your Debit/Credit card. In conjunction with HIPPA regulations, all card information will be kept confidential.

CONFIDENTIAL PATIENT INFORMATION

Patient Name:_____ **Date of Birth:**_____

Social Security: **Sex at Birth: M or F Gender ID:**_____

Home Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Mailing (if different)_____ **Home Phone#:**_____

Cell#:_____ **Email Address:**_____

Appointment Confirmation Preference:

Circle one: **Call** **Text** **Both** **No Confirmation**

Confirmation Calls are a COURTESY. Calls can fail, voicemail boxes can be full, and other complications can occur. Please do not rely on them to keep track of your appointments.

Emergency Notification

Name:_____ **Relationship:**_____ **Phone#:**_____

Physician Information

Referring Physician:_____ **Primary Care Physician:**_____

Insurance Information

Insurance cards provided upon arrival

OR

Primary Insurance

Policy Name:_____ **Policy#**_____

Policy Holder:_____ **DOB:**_____ **Relationship:**_____

Secondary Insurance

Policy Name:_____ **Policy#**_____

Policy Holder:_____ **DOB:**_____ **Relationship:**_____

Workers Compensation Insurance

Company:_____ **Claim#**_____

Case Manager:_____ **Phone#**_____ **Fax#**_____

Employer at time of injury:_____

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 assignments 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)

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)

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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.

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

This signature serves as your acknowledgement and understanding of both The Patient Privacy Policy and Procedures Statement as well as The Consent for Care and Treatment listed above.

Moreland Physical Therapy
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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, 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:

- **If any portion is not paid by my insurance, I agree to make arrangements for prompt payment of the bill in full.**
- **You are responsible for notifying us immediately should your insurance change. If you fail to provide us with the correct information in a timely manner, you will be responsible for the resulting balance**
- **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.**
- **If you do not show up for an appointment or cancel with less than 24-hours notice you will be charged $80.**
- **Workers compensation cases require written approval/authorization by your 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, and you agree to pay the additional amount.**
- **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:**_____