PATIENT REGISTRATION

Date: ______________________ **Date of next MD visit**___/___/___ **Date last seen** by referring MD:___/___/___

Patient Last name______________________________ **First**_________________________ **Middle**________________

Mailing / Physical Address____ **SSN**____________________

City____ **State**_________________ **Zip Code**__________________

Home Phone(_____)_________________ **Cell Phone** (____)_________________ **Work Phone**(______)_______________

Date of Birth__________ **Gender:** Male Female **Marital Status**: S M D W **Email address**______________________

Patient Employer:____ **Employer Phone #**: (_____)___________________

Have you had home health or physical therapy this year? ( ) Y ( ) N If so, where?________________________________

Please provide contact information where someone can be reached in case of emergency while patient is receiving therapy.

Name: ____ **Relationship:** ______________________

Home Phone(_____)_________________ **Cell Phone** (____)_________________ **Work Phone**(______)_______________

Treatment Consent & Authorization

Ambulatory Care Authorization

I, ________________________________(patient or responsible party), hereby voluntarily authorize Moreau Physical Therapy to perform outpatient evaluation(s) and/or procedure(s) and to administer such outpatient therapy treatment(s) that in the opinion of the physician and consulting allied health provider is/are necessary or appropriate. It has been explained to me that medical treatment/therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

Patient's Signature____ Date _______/_______/______

Other/Responsible Party's Signature____ Date_______/______/_______

Reason patient cannot sign____

Authorization to Release Information

I, the undersigned, hereby authorize Moreau Physical Therapy to release medical record information by means of telephone, reproduction, or facsimile transmission, relative to any outpatient therapy, treatment(s), or evaluation(s) to referring physician for status of treatment, family physician providing follow-up care, third party payer(s) to substantiate medical necessity and charge verification, and/or case manager(s) for determining medical necessity or utilization review.

This authorization shall be valid during the course of treatment and shall expire 365 days after discharge.

Patient's Signature____ Date _______/_______/_________

Other/Responsible Party's Signature______________________________________ Date_______/_______/__________

Reason patient cannot sign:____

MOREAU PHYSICAL THERAPY - MEDICAL HISTORY

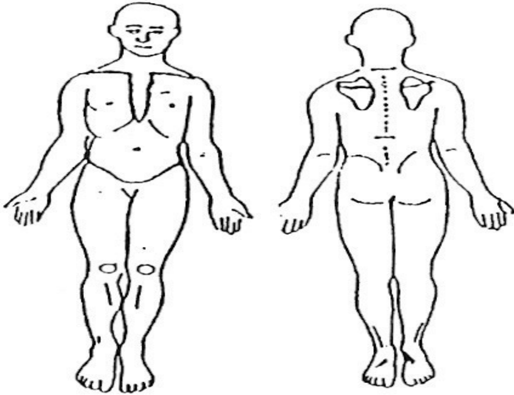
Patient Last name___________________________ **First**_____________________________ **Middle**__________________

Condition related to: ( ) **Employment** ( ) **Auto Accident** ( ) **Other** ____________________________________

Date condition/injury began: ___________ **Body Site of Condition/Injury:** ___________ **Date of Surgery:** _____________

Currently working? ___ Yes ___No If Yes, please give your your occupation and describe demands: ___________________
____
____

Pain Scale: It is important that we have a measure of your pain. Please rate the level of your pain on a scale of 1-10
1 2 3 4 5 6 7 8 9 10
Mild Moderate Extreme



Which of these words describes your pain?
(Check all that apply)

___Sharp ___Dull ___Burning

___Aching ___Tingling ___Numb

___Constant ___Variable ___Radiating (moves)

On the models to the left, please shade the area of your body where your pain is present.

Are there any positions or activities that make your pain worse? ____
Are there any positions or activities that lessen your pain? ____

Medical Conditions (circle Yes or No)

Allergies	Yes	No		Leg Injury / Surgery	Yes	No
Anemia	Yes	No		Lung Disease	Yes	No
Back Injury/Surgery	Yes	No		Nausea / Vomiting	Yes	No
Blood Clot	Yes	No		Neck Injury / Surgery	Yes	No
Broken Bones – List:	Yes	No		Numbness / Tingling	Yes	No
Cancer or Chemotherapy Radiation	Yes	No		Osteoarthritis	Yes	No
Chest Pains	Yes	No		Osteoporosis	Yes	No
Coronary Heart Disease	Yes	No		Pacemaker	Yes	No
Diabetes	Yes	No		Pins / Metal Implants	Yes	No
Dizziness / Vertigo	Yes	No		Pregnant	Yes	No
Elbow / Hand Injury	Yes	No		Respiratory Problems	Yes	No
Fibromyalgia	Yes	No		Rheumatoid Arthritis	Yes	No
Fractures	Yes	No		Seizures – Type:	Yes	No
Headaches	Yes	No		Shoulder Injury / Surgery	Yes	No
Heart Attack / Surgery	Yes	No		Shortness of Breath	Yes	No
Hernia	Yes	No		Smoker	Yes	No
High Blood Pressure	Yes	No		Stroke	Yes	No
Hip Injury / Surgery	Yes	No		Vision or Hearing Problems	Yes	No
History of Falling	Yes	No		Weakness	Yes	No
Incontinence	Yes	No		Weight Loss	Yes	No
Increased pain at night	Yes	No		Recent Procedures	Yes	No
Infectious Disease	Yes	No		Recent Injections	Yes	No
Joint Replacement	Yes	No		Restrictions with Walking / Exercising	Yes	No
Kidney / Urinary Tract Disease	Yes	No				
Knee Injury / Surgery	Yes	No				

List any medications and the reason you are taking: ____

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MOREAU PHYSICAL THERAPY

OUR FINANCIAL POLICY

Thank you for choosing **Moreau Physical Therapy** as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the therapist.

- The part of the bill that you owe is always required at the time of service. We do not bill our co-pays, deductibles, or the part your insurance does not pay. **FULL PAYMENT IS DUE AT TIME OF SERVICE**.
- We make it easy to collect payment at the time of service. You may choose to pay with cash, check or credit card. A convenient option is Our EASY-PAY program allows us to capture your credit card/ debit card on file.
- If you are uninsured, all fees are required at the time of service.

Regarding Insurance or Other Third Party Liability Claims:

We will accept assignment of insurance benefits. The balance is your responsibility whether your insurance company or another third party pays or not. We cannot bill your insurance company or other liability plan unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company does not pay timely, we will contact you. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes, it is your responsibility to give us the corrected information.

Regarding HMO/PPO plans or other Indemnity Insurance: PLEASE READ:

We will verify benefits prior to your first therapy visit. We determine your patient balance at each visit based on the information given to us by your insurance company. Sometimes we are quoted differently than your claim is processed. When this occurs you will be notified. Please keep in mind that some claims require 30-45 days to process after the time of service has occurred. If a balance is owed after processing of claims, you will be responsible for the unpaid balance.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Previous Therapy

It is your responsibility to notify us if you have attended therapy elsewhere or received Home Health in the past year as this may affect your patient balance.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at time of service.

Missed appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $20. Please help us serve you better by keeping scheduled appointments.

Interest

We reserve the right to charge interest in the amount of 12% as provide by state law for a rebilling fee. Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy:

X ______________________________________ Date ________________________________

Signature of Patient or Responsible Party

I understand that, under the Healthcare Portability and Accountability Act of 1996 (HIPPA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- Contact, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of uses and disclosures on my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name: ____

Signature: ____ Date: ___________________________

Relationship to patient: __________________________________

Patient Easy Pay Consent

I authorize Moreau Physical Therapy to charge my credit card/debit card for the balance of charges not paid by my insurance for therapy services.

- ☐ Monthly: will be drafted on the 1st or 15th of the month. (Please note if the 1st or the 15th of the month is a holiday or weekend, then your account will be drafted on the following business day.)
- ☐ Weekly: will occur each Thursday
- ☐ Per Visit

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

____ __________________________
Cardholder Signature Date

Patient Name		
Cardholder Name		
Cardholder Address		
City	State	Zip
☐ Visa ☐ MasterCard ☐ Check Card ☐ Discover ☐ Other Credit Card Number		Exp. Date