



PATIENT INFORMATION FORM

Patient Name: _____
(First) (MI) (Last)

Mailing Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Gender: Male Female

Date of Birth: _____ Home Phone #: _____

Marital Status: **S M D W** Spouse: _____

Your Employer: _____ Work #: _____

Business Address: _____

Person you want us to contact in case of an emergency: _____

Phone #: _____ Relationship: _____

Type of claim: Health Insurance _____ Worker's Comp _____ Auto _____

Name on your Insurance card _____

Relationship to the patient _____

Are you currently active in the military/reserves/national guard? _____

Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY FORM

Name: _____ Age: _____ Occupation: _____

Have you had any physical therapy in the past year? _____ If yes, for what condition?

_____ Was treatment effective? _____

Date that injury occurred: _____ Area(s) of symptoms: _____

Current level of pain: (None) 0___1___2___3___4___5___6___7___8___9___10___ (Extreme)

Activities that increase your pain: _____

How do you relieve the pain? _____

What are your goals for physical therapy? _____

MEDICAL HISTORY

Do you have any history of: (please circle)

High blood pressure	Yes	No	Pacemaker	Yes	No
Heart condition	Yes	No	Seizures	Yes	No
Stroke	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Arthritis	Yes	No
Osteoporosis	Yes	No	Head trauma	Yes	No
Head or spine surgery	Yes	No	Fractures	Yes	No

List any other medical conditions not specified above: _____

List all current medications and reason for medication: _____

List any surgical procedures you have had in the past 5 years: _____

List activities that you do on a regular basis (walking, exercise, gardening, swimming, etc.) _____

Name of orthopedic doctor: _____ Name of family doctor: _____

Signature: _____ Date: _____

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IMPORTANT INFORMATION

PLEASE READ ALL OF THE FOLLOWING AND ACKNOWLEDGE BY SIGNING

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: I understand that I am responsible for my medical expenses. I understand that although I may have insurance coverage, there are times when my insurance company may assign some responsibility for payment to me. I agree to pay those amounts determined by my insurance company to be my responsibility whether or not I have received my injuries from an accident with another person at fault.

COLLECTION COSTS: I agree that should my account balance become delinquent more than 90 days that I will pay for all costs incurred by Mosher Physical Therapy and Sports Medicine PC for the collection of my delinquent account including but not limited to legal fees, court costs, and collection agency costs.

CANCELLATION FEE: I agree to try to notify Mosher Physical Therapy and Sports Medicine at least 24 hours in advance of an appointment I need to cancel. I understand that a \$25.00 fee may be applied to my account if I repeatedly fail to show without notice of cancellation for scheduled appointments.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Mosher Physical Therapy and Sports Medicine PC for the medical benefits of my insurance plan. I also authorize any and all parties receiving payment on my behalf related to these medical costs (including any attorney I may choose to involve in my case) to pay the full balance of my account directly to Mosher Physical Therapy and Sports Medicine PC.

EXPLANATION OF BENEFITS: I understand that the patient accounts specialist will contact my insurance to determine what type of benefits my insurance policy will pay for my physical therapy care. I understand that the explanation of benefits given to me by the staff of Mosher Physical Therapy and Sports Medicine PC is given as a courtesy, and may differ from the exact processing of my medical claims. I also understand that it is my responsibility to understand my own insurance benefits, and that I am also able to get that information directly from my insurance company. I agree not to hold Mosher Physical Therapy and Sports Medicine PC responsible for any differences between explanation of benefits provided to them by my insurance company, and the actual processing of my medical claims by my insurance company.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

RELATIONSHIP TO PATIENT

DATE

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Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our HIPAA consent agreement. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information may be used for appropriate purposes including the following specific purposes:

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment reminders
- To run our Practice more efficiently and ensure all our patients receive quality care.
- For continuing education
- To avert serious threat to health or safety
- For worker's compensation programs
- In response to certain requests arising out of legal or other disputes

I have received a copy of the Notice of Privacy Practices: _____
Signature Date

I authorize Moshier PT and Sports Medicine to leave basic messages regarding appointment times and schedule changes on my voicemail or answering machine, or with those individuals answering the phone numbers I have provided.

I do not authorize Moshier PT and Sports Medicine to leave basic messages on my voicemail, answering machine, or with other individuals answering the phone numbers I have provided.

The following authorization is optional and does not need to be completed unless you specifically wish your records released to or accessed by a particular person or entity.

Authorization form for Other Uses of Protected Health Information

Complete or check all those that apply:

Please disclose my Entire _____ or Specific _____ records to the following entity:

Other: _____

Other: _____

Address: _____

Address: _____

Fax: _____

Fax: _____

Specific information to be released: _____

Expiration date of this authorization: 18 months Perpetual

The above mentioned PHI may be subject to further or Re-disclosure by the party receiving the information and may no longer be protected by the privacy rules upon such disclosure. Your signature authorizes us to use and disclose protected health information (PHI) as provided herein. You have the right to revoke this authorization at any time, in writing, signed by you and directed to our Privacy Officer who is **Danielle Moshier**. However, such revocation shall not affect any disclosures we have already made in reliance on your prior authorization or consent.

This Authorization was signed by: _____ Date: _____
Printed Name of Patient or Representative

SIGNATURE: _____
Relationship to Patient (if other than Patient): _____

Witness: _____ Date: _____
Signature of Practice Representative

Printed Name: _____

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