MOVEMENT ARTS PHYSICAL THERAPY

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PATIENT NAME: LAST_____FIRST_____MI_____

DATE OF BIRTH:_____GENDER_____ MARITAL STATUS_____

ADDRESS:_____CITY_____STATE_____ZIP_____

PHONE NUMBER: HOME ☐ _____MOBILE ☐ _____WORK ☐ _____

(PLEASE CHECK PRIMARY CONTACT NUMBER)

EMAIL ADDRESS_____

IDENTIFICATION: (SSN OR DRIVERS LICENSE NUMBER)_____

EMPLOYER NAME:_____

EMERGENCY CONTACT: NAME_____PHONE NO._____

PRIMARY INSURANCE:_____GROUP NO:_____POLICY NO:_____

NAME OF INSURRED:_____DOB:_____RELATIONSHIP:_____

SECONDARY INSURANCE:_____GROUP NO:_____POLICY NO:_____

NAME OF INSURED:_____DOB:_____RELATIONSHIP:_____

PLEASE LIST ANY MEDICATIONS/SUPPLEMENTS YOU ARE TAKING:

_____

_____

REFERRING PHYSICIAN:_____PRIMARY PHYSICIAN:_____

SELF REFERRED YES NO HOW DID YOU HEAR ABOUT OUR OFFICE?_____

DATE OF INJURY_____

HAVE YOU HAD ANY PRIOR PHYSICAL THERAPY SERVICES THIS CALENDAR YEAR? YES NO

IF YES, WHERE_____HOW MANY_____WHEN WAS YOUR LAST VISIT_____

Client/Guardian Signature:_____ Date:_____

PATIENT CONSENT TO TREAT

I authorize Movement Arts Physical Therapy to render appropriate treatment provided by appropriate personnel and understand that I have the right to refuse treatment.
Initial_____

I authorize Movement Arts Physical Therapy to obtain or provide emergency care if conditions warrant while at the facility if I am unable to give consent (CPR/emergency care).
Initial_____

Patient Rights/Expectations:

1. To be informed of the nature of their conditions, proposed treatment, and expected risks and results.
2. To be a participant in the plan of care and informed about the treatment plan. This includes refusal of all or part of the suggested treatment plan after being informed of any potential consequences of participation in the treatment plan.
3. To voice any grievances regarding care or treatment.

Clinic Rights/Expectations:

1. To obtain a complete and accurate medical history and any other necessary information in a timely fashion.
2. Patient will read and understand or ask questions regarding any forms or documentation.
3. Patient will participate in the plan of care and adhere the treatment plan, including home program.
4. Patient will immediately report to the therapist any stress or discomfort that may be elicited during treatment.
5. Patient will be present and on time for appointments.

Client/Guardian Signature: _____Date:_____

HIPAA FORM

I acknowledge that I have been presented with a copy of the MAPT Notice of Privacy Practices form as required by the Health Insurance Portability and Accountability Act of 1996. (see laminated page)

Client/Guardian Signature: _____Date:_____

FINANCIAL POLICY

We would be glad to bill your insurance and accept assignment of insurance benefits. Please initial and sign the following to indicate that you understand and accept these terms.

Insurance is a contract between the patient or guarantor and the insurance company and Movement Arts Physical Therapy Inc. bills only as a courtesy to patients. I am financially responsible to MAPT for services rendered.
Initial_____

MAPT can, as a courtesy, call my insurance company for benefits. I understand that information relayed by the insurance company to MAPT is not a guarantee of coverage and I am responsible for understanding my insurance benefits and limitations.
Initial_____

I understand that MAPT may not accept my insurance payments as payment in full. I am responsible for deductibles, co-payments, co-insurance and non-covered items/services. I agree to pay all such balances.
Initial_____

I understand that it is my responsibility to obtain all necessary referrals and physician prescriptions as required by my insurance company. Prescriptions must be kept current on monthly basis. Any request/contact made by MAPT for prescriptions/authorizations is done so as a courtesy.
Initial_____

Appointment cancellations with less than 24 hour notice, and no show appointments will be charged $50. This charge is not covered by my insurance and it is my responsibility to pay this fee.
Initial_____

I understand and agree to this financial policy.

Client/Guardian Signature: _____Date:_____

Assignment of Benefits

I hereby authorize my insurance company to pay all benefits directly to Movement Arts Physical Therapy, Inc. 2239 Townsgate Road Suite 101, Westlake Village, CA 91361.

Client/Guardian Signature: _____Date:_____