MOVEMENT ARTS PHYSICAL THERAPY
LAUREN FOX MPT, KATHY JOHNSON MPT, GALEN OKAZAKI MPT
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PATIENT NAME: LAST_____FIRST_____MI____

DATE OF BIRTH:_____AGE_____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)_____

EMERGENCY CONTACT: NAME_____PHONE NO._____

EMPLOYER NAME:_____PHONE NUMBER:_____

PRIMARY INSURANCE:_____GROUP NO:_____POLICY NO:_____

NAME OF INSURED:_____DOB:_____RELATIONSHIP:_____

SECONDARY INSURANCE:_____GROUP NO:_____POLICY NO:_____

NAME OF INSURED:_____DOB:_____RELATIONSHIP:_____

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_____

PLEASE LIST ANY MEDICATIONS/ SUPPLEMENTS YOU ARE TAKING (INCLUDING DOSAGE, METHOD AND FREQUENCY)

_____

_____

_____

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

- **Payment is due at the time of service.**
  We collect $170 for Initial Evaluation, $150 for Regular visits.

Please initial and sign below to indicate that you understand and accept these terms.

If your insurance company sends MAPT payment towards your visit, your account will be credited. Payments are monitored adjusted weekly. Initial _____

- **We will be glad to bill your insurance company as a courtesy to you.**

Insurance is a contract between the patient or guarantor and the insurance company.
The amount of reimbursement is dependent on the contract you have with your insurance company
Initial_____

- **It is the patient's responsibility to be sure you are covered for this visit.**

A Insurance verification form is available to help you verify your out of network physical therapy benefit on request. Initial_____

- **I understand that MAPT may not accept my insurance 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_____

- **My insurance company may choose to send reimbursement checks to me in the mail.**

These checks are intended to reimburse physical therapy insurance responsibilities, not copays or patient portions of deductibles Initial _____

- **I understand that it is my responsibility to obtain all necessary referrals and physician prescriptions as required by my insurance company.**

Any request/contact made by MAPT for prescription/authorizations is done so as a courtesy.
Initial _____

- **Cancellation policy**

Appointment cancellations with less than 24 hour notice , and no show appointments will be charged at $50.00.
Your insurance company will not be billed for a misses or cancelled appointment. 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: _____