HEALERS OF MOTION PHYSICAL THERAPY

PATIENT REGISTRATION

This is a confidential health record. No information will be released without your permission and written authorization.

PATIENT DEMOGRAPHICS

Name: First _____Middle _____ Last_____
Date of Birth (Month/Day/Year) _____/_____/_____ Age_____
Gender: Female_____ Male_____

Home Address:

Street**:** _____

City, State & Zip Code: _____

Telephone Numbers/Email: ***Please, circle preference to get in contact to you.***
Home: _____ Cell: _____ Work: _____
Fax: _____ Email: _____

In Case of Emergency, Notify:

Name: _____ Telephone_____Relationship_____

Primary Care Physician: _____ Tel: _____
Have you visited your medical doctor during the last six months? ____yes ____no

Date of last visit:_____

Regular primary care by a licensed medical doctor is an important choice that is strongly recommended by this clinic's practitioners.

NOTE: There will be a $20.00 charged fee for not showing up to your appointments, unless 24 hours notice is given.

Patient's signature: _____

Registration date: _____

Healers Of Motion
Physical Therapy

HEALERS OF MOTION PHYSICAL THERAPY

Dr. Evelyn Mora, PT, DPT

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of Physical Therapy treatments and other procedures within the scope of the practice of Physical Therapy on me (or on the patient named below, for whom I am legally responsible) by the Licensed Physical Therapist EVELYN MORA and/or other physical therapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the physical therapist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.
By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatments for my present condition and for any future condition(s) for which I seek treatment.

I **give my permission and consent to treatment.**

Print patient's Name:_____

Sinature: _____ **Date:**_____

Representative signature if patient is a Minor or Impaired_____

Representative please indicate relationship with the patient_____

HEALERS OF MOTION
PEMBROKE PINES PHYSICAL THERAPY

Name: _____ Age: _____ Date:_____

Major Complain: _____

_____

_____

Date Of Onset(when you first noticed your problem):_____

How long have you had this condition?_____

Is your Condition: _____Getting worse _____Constant _____Intermittent

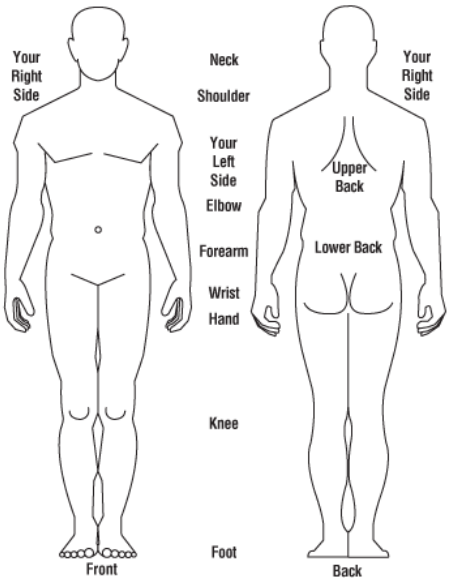
What makes it better?_____

What makes it worse?_____

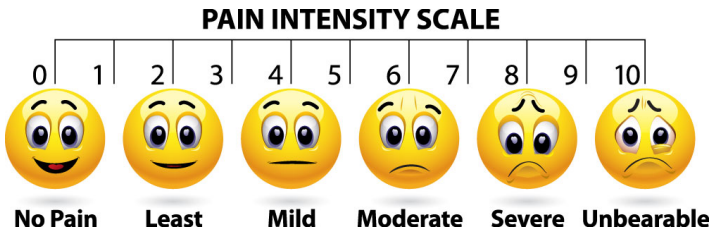
Is the pain:
____Dull ____Stabbing ____Burning ____Throbbing ____Sharp

Is pain radiated(goes to any other area of your body)?:_____

Please mark the areas of pain



Please circle the number which correspond to pain level



Do you now have or have you ever had the following:

- ☐ Do you smoke?
- ☐ Asthma
- ☐ Bronchitis / Emphysema
- ☐ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Latex Sensitivity / Allergy
- ☐ Celulitis
- ☐ Arthritis
- ☐ Cancer: Location_____
- ☐ Chemotherapy ☐ Radiotherapy
- ☐ Diabetes
- ☐ Stroke
- ☐ Pacemaker / Atrial Fibrillation
- ☐ Headache
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Other: _____

Medications you are currently taking:_____

_____

Surgeries (include date of procedure): _____

_____

Do you have any precautions? Have you been told things to avoid?

____ Yes_____ No, If yes, please explain:
_____

_____

Patient/Family/Guardian Signature: _____

Healers Of Motion Physical Therapy

PATIENT FINANCIAL RESPONSIBILITY

- **_____ Insurance Coverage:** It is the patient's responsibility to be familiar with their insurance coverage, policy provisions, exclusions, and limitations, as well as requirements for authorizations. We attempt to verify that your coverage is active at the time of your visit. However, we depend on you to provide us with the most accurate information. If for any reason, your coverage is not active, you must know that the cost of the visit is your responsibility.
- **_____ Co-Payment, Co-Insurance and Deductibles:** Co-Payments must be paid at the time of your visit. If your plan has a deductible and/or co-insurance, we will collect a portion at the time of your visit and the remainder will be billed to you once your insurance has processed the claim.
- **_____ Change of Insurance:** You must notify us immediately if you have had any changes to your insurance coverage.
- **_____ Referrals:** Whenever referrals are required by your insurance plan it is your responsibility to obtain them. We will assist you with this process if possible. You must notify us immediately if you change your Primary Care Physician and obtain a new referral.
- **_____Non-Covered Services:** Patients are responsible for non-covered services when they are denied by their insurance company.

I have read the statements above regarding my financial responsibilities. By signing below, I affirm that I clearly understand my financial responsibilities. I understand that if coverage and/or payment for any physical therapy services provided to me by Healers of Motion Physical Therapy is denied by my insurance company, I assume financial responsibility and will pay all such charges.

_____ _____

Patient or Authorized Representative Signature Date

_____ _____

Print Patient or Authorized Representative Name Relationship to Patient

_____ _____

Witness Signature Date

HEALERS OF MOTION PHYSICAL THERAPY

EVELYN MORA PT, DPT
18503 Pines Blvd., Suite 309, Pembroke Pines, FL 33029

(954) 861-0252

Patient acknowledgment of receipt of Notice of Privacy Practices

I acknowledge I had received the “Notice of Privacy Practices”

Signature_____ Date_____

Name_____ Phone_____

Representative Signature if Patient is a Minor or Impaired:

_____

Representative please print your name and indicate relationship with the patient:

_____

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OFFICE ONLY

Signed from received by_____

Acknowledgment refused:

Efforts to obtain:_____

Reson for refusal:_____