**HEALERS OF MOTION PHYSICAL THERAPY**

**PATIENT REGIRSTRATION**

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

**PATIENT DEMOGRAPHICS:**

NAME: _____MIDDLE: ___LAST: _____

DATE OF BIRTH(Month/Day/Year): ___/___/___ AGE: _____

**HOME ADDRESS:**

STREET: _____

CITY, STATE & ZIP CODE: _____

**TELEPHONE # / EMAIL: (PLEASE, CIRCLE PREFERENCE TO GET IN CONTACT WITH YOU).**

HOME: _____CELL: _____WORK: _____

FAX: _____EMAIL: _____

**IN CASE OF EMERGENCY, NOTIFY:**

NAME: _____PHONE: _____RELATIONSHIP: _____

**PRIMARY CARE PHYSICIAN:** _____PHONE: _____

Have you visited your medical doctor during the last 6 months? _____YES____NO

DATE OF LAST VISIT: _____

**REGULAR PRIMARY CARE BY LICENSED MEDICAL DOCTOR IS AN IMPORTANT CHOICE THAT IS STRONGLY RECOMMENDED BY THIS CLINIC'S PRACTITIONERS.**

**THERE WILL BE A $50.00 CHARGE FEE FOR NOT SHOWING UP TO YOUR APPOINTMENTS, UNLESS 24 HOURS NOTICE IS GIVEN. CREDIT CARD INFORMATION WILL BE KEPT ON FILE. THANK YOU FOR UNDERSTANDING!**

**PATIENT'S SIGNATURE:** _____**TODAY'S DATE:** _____

HEALERS OF MOTION PHYSICAL THERAPY
DR. EVELYN MORA, PT, DPT, Cert. DN

# INFORMED CONSENT TO TREAT

I AUTHORIZE AND CONSENT TO RECEIVING PHYSICAL THERAPY TREATMENTS AND OTHER PROCEDURES WITHIN THE SCOPE OF PHYSICAL THERAPY PRACTICE FROM DR. EVELYN MORA OR OTHER PHYSICAL THERAPISTS WORKING AT THE SAME CLINIC OR OFFICE, WHETHER THEY HAVE SIGNED THIS FORM OR NOT.

BY SIGNING BELOW, I CONFIRM THAT I HAVE READ OR HAD THE ABOVE CONSENT TO TREATMENT. THIS CONSENT FORM APPLIES TO ALL THE TREATMENTS FOR MY CURRENT CONDITION AND ANY FUTURE CONDITIONS FOR WHICH I SEEK TREATMENT.

I GIVE MY PERMISSION AND CONSENT TO TREATMENT.

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

REPRESENTATIVE SIGNATURE IF PATIENT IS A MINOR OR IMPAIRED: _____

REPRESENTATIVE, PLEASE INDICATE RELATIONSHIP WITH THE PATIENT: _____

**HEALERS OF MOTION PHYSICAL THERAPY CENTER**

**DR. EVELYN MORA PT, DPT, Cert. DN**

**18503 PINES BLVD., SUITE 308 PEMBROKE PINES, FL 33029**

**954-861-0252**

**727-227-7228 FAX**

## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE I HAD RECEIVED THE "NOTICE OF PRIVACY PRACTICES"

SIGNATURE: _____ DATE: _____

NAME(PRINT): _____ PNONE: _____

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: _____**

**REASON FOR REFUSAL: _____**

**HEALERS OF MOTION PHYSICAL THERAPY**
**DR. EVELYN MORA PT, DPT, Cert.DN**
**18503 PINES BLVD, SUITE 308 PEMBROKE PINES, FL 33029**
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# AUTHORIZATION TO PAY BENEFITS TO PROVIDER
## THE PRIVATE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND THE INFORMATION RELEASE

I, _____, hereby unequivocally authorize the direct payment of and delivered to in the name of HEALERS OF MOTION PHYSICAL THERAPY, the medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. I understand that I will be financially responsible for any fees applied by the insurance company per my contract.

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within 60 days, you (patient) will be responsible for the full balance amount due.

**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 time of 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 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.

**Issued checks:** This payment shall not exceed my indebtedness to the above-mentioned assigned. I understand, if the insurance company is to issue checks under my name, I am obligated to endorse those payments to HEALERS OF MOTION PHYSICAL THERAPY for Professional Services received and have not been paid to me. I understand that in the event of denied payment(s) by the insurance company, I am just responsible for the remaining balance the insurance company has not paid.

I have read the statements above regarding my financial responsibilities. By signing below, I affirm that I clearly understand my financial obligations. 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.

**Released documents:** It is my intention that this document reflects my authorized assignment of my rights and benefits under the terms and policy agreement. Further, I hereby extend authorization for the release of any pertinent information to my case to any insurance company, adjuster, or law office involved, and that a photocopy of this document shall have the authority of and be treated as original.

**NAME(PRINTED): _____**

**SIGNATURE: _____**

**DATE: _____**

Healers Of Motion
Physical Therapy

**NAME:** _____**AGE:**_____**DATE:** _____

**MAJOR COMPLAINT:**

_____

_____

_____

DATE OF ONSET (WHEN YOU FIRST NOTICED YOUR PROBLEM): _____

HOW LONG HAVE YOU HAD THIS CONDITION: _____

IS YOUR CONDITION: _____GETTING WORSE_____CONSTANT_____

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)?** _____

## DO YOU NOW HAVE, OR HAVE EVER HAD THE FOLLOWING?

- DO YOU SMOKE?
- ASTHMA
- BRONCHITIS/EMPHYSEMA
- SHORTNESS OF BREATH
- HIGH BLOOD PRESSURE
- LATEX SENSITIVITY/ALLERGY
- CELLULITIS
- ARTHRITIS
- CANCER: LOCATION_____
- CHEMOTHERAPY
- RADIOTHERAPY
- DIABETES
- STROKE
- PACEMAKER / ARTIAL FIBRILLATION
- HEADACHE
- FIBROMYALGIA
- OSTEOPOROSIS
- OTHER:_____

## MEDICATION YOU ARE CURRENTLY TAKING:

_____

_____.

## SURGERIES (INCLUDE THE DATE OF PROCEDURE):

_____

_____.

## DO YOU HAVE ANY PRECAUTIONS? HAVE YOU BEEN TOLD THINGS TO AVOID?

## ____YES____NO, IF YES, PLEASE EXPLAIN.

_____

_____.

**PATIENT/GUARDIAN SIGNATURE:**_____