

Mobile Therapy Services

TEL: (570) 282 9382 FAX: (570)-227-1891

NOTICE OF PATIENT PRIVACY AND FINANCIAL AGREEMENT

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How Medical Information About You May Be Used And Disclosed And How You Can Access This Information

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask us and we will provide you with a copy. If you have any questions, concerns, or complaints about the Notice or your medical information, please contact us at the number above.

Release Of Medical Information Necessary to Process Claims

I authorize the release of all medical or other information needed to process this medical claim. I also request payment of government benefits to the party who accepts assignment below.

Cancellation Policy

We require 24 hours notice in the event of a cancellation. There is a \$100.00 charge for a cancellation without proper notice. Your insurance will not cover the penalty amount and you will be responsible for this charge.

Assignment of Benefits / Consent for Physical Therapy, Occupational, and Speech Therapy

I, the undersigned due hereby agree and give my consent for **Mobile Therapy Services** to furnish physical therapy, and/or occupational therapy, and/or speech therapy services to myself or dependent, which is considered necessary and proper in evaluating and treating myself or dependent for my/their physical condition. I assign them all payments for medical services rendered. I acknowledge that they will bill my insurance company on my behalf. In the event medical payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments along with the Explanation of Benefits to **Mobile Therapy Services**. I accept financial responsibility for all charges incurred. I understand that I am to pay any deductibles, co-payments, or other charges not covered by my insurance company. If my account has to be referred for outside collections, I will be charged a \$30 service charge. For all returned checks, there is a \$20 penalty in addition to the immediate cash payment for services rendered. I also authorize **Mobile Therapy Services** to furnish any necessary information concerning injury/illness to the insurance carrier involved.

I have read and fully understand the above information.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____

Patient Email: _____

Ok to contact Via email: Yes: _____ No: _____



*27 Main Street
Dallas, Pennsylvania 18612*

Dear Valued Patient,

We require 24 hours notice in the event of a cancellation. Please be advised that if for any reason you must cancel your appointment less than 24 hours notice we will enforce our cancellation fee of \$100.00, it is our company policy that Mobile Therapy Services receives notification 24 hours prior to your scheduled visit.

Mobile Therapy Services is unique in that we only book 1 : 1 appointments to provide you with the best quality of care and individualized attention. No shows and cancellations with less than 24 hours are detrimental to your care and many times with late notice we cannot schedule another patient.

In the event that you are hospitalized, please make every effort to contact the office at 570 282 9382.

Your insurance will not cover the penalty amount and you will be responsible for this charge. Missed/late canceled appointments prevent other patients the opportunity for an appointment and affect the consistency of your own rehabilitation program.

We do our best to verify patient insurance before the start of care. However it is the patient responsibility to know their insurance policy.

We appreciate your cooperation with this policy. We're looking forward to working with you!!

I have read and understand the cancellation policy and Give Mobile Therapy Services Permission to keep my credit card information on file.

Patient Name: _____ **Date:** _____

Patient Signature: _____

Guardian/Caregiver Signature: _____

Credit Card:# _____

Credit Card 3 digit Code: _____

Credit Card Expiration: _____

Credit Card Billing Zip Code: _____

**Mobile Therapy Services
MEDICAL HISTORY**

Patient Name: _____ DOB: _____

Primary Care Physician: _____

Please circle any that apply to your medical history:

High Blood Pressure

Heart Disease

Numbness

Pacemaker

Shortness of Breath

Female Issues

Weakness

Pregnant

Night Pain

Stroke

Diabetes

Dizziness

Irregular Heart Rate

Fatigue

Osteoporosis

Headaches

List any other medical history: _____

Have you fallen in the past year? YES – NO Height: _____ Weight: _____

Medications: _____

Surgeries: _____

General Health: (circle one) Poor Fair Good Excellent

In the past 3 months have you experienced any significant changes in health? (physical or mental):

CURRENT COMPLAINT

Current Complaint: _____ Start Date: _____

How did it start? _____ Previous Therapy: YES – NO

Does your pain radiate? YES – NO Where: _____ Pain Level (0-10): _____

Surgical Date if Applicable: _____ Surgeon: _____

Restrictions: YES – NO _____ Diagnostics Tests: _____

Signature: _____ Date: _____



27 Main Street
Dallas, PA 18612

Intake Information

What Are Your Top 3 Problems?

1. _____

2. _____

3. _____

What Are Your Top 3 Goals With Therapy?

1. _____

2. _____

3. _____
