KINETIC
PHYSICAL THERAPY

1406 Shadywood Ln | Mt. Pleasant, TX 75455 | OFFICE: 903-572-6100 | FAX: 903-572-6127

213 Hwy 37 | Mt. Vernon, TX 75457 | OFFICE: 903-270-6221 | FAX: 903-270-6223

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PATIENT NAME: FIRST_____MIDDLE_____LAST_____ SEX: [ ] M OR [ ] F

DATE OF BIRTH: _____ MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ CELL #: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____ EMPLOYER NAME & PHONE:_____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

WHO MAY WE CALL IN CASE OF AN EMERGENCY: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? _____

********** **BILLING INFORMATION** **********

WAS YOUR INJURY A RESULT OF A **WORK RELATED INCIDENT** OR DID IT OCCUR WHILE ON THE JOB? [ ] **YES** [ ] **NO**

WAS YOUR INJURY A RESULT OF A **MOTOR VEHICLE ACCIDENT**? [ ] **YES** [ ] **NO**

ARE YOU CURRENTLY ENROLLED IN **HOME HEALTH** OR HAVE YOU BEEN IN THE LAST 30 DAYS? [ ] **YES** [ ] **NO**

DATE OF INJURY, SYMPTOMS OR SURGERY : _____
PRIMARY INSURANCE CARRIER: _____
ID#: _____ GROUP#: _____
EMPLOYER NAME FOR THIS INSURANCE: _____
INSURED DATE OF BIRTH: _____ SEX: M OR F

1. SECONDARY INSURANCE: _____
ID#: _____ GROUP#: _____
EMPLOYER FOR THIS INSURANCE: _____
INSURED DATE OF BIRTH: _____ SEX: M OR F

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits to be made directly to Chambers Outpatient Rehab Services dba Kinetic Physical Therapy Associates. I understand and agree to allow this office to use the Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care and benefits. I understand that I am responsible for all costs of care regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for profesional services will be immediately due and payable.

PATIENT AND/OR GUARDIAN SIGNATURE: _____ DATE: _____

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PATIENT FINANCIAL RESPONSIBILITY AND CONSENT TO TREAT

INSURANCE

- I, _____, consent to physical therapy services performed by the staff of Kinetic Physical Therapy Associates as well as allowing them to bill my primary and/or secondary insurance(s) for services rendered. Once billed, I authorize my health insurance provider to make direct payment(s) to Kinetic Physical Therapy Associates. After verification of insurance benefits, the estimated amount I will be responsible for is $_____ due prior to or immediately after each daily visit. Any remaining balances will be due at the date of discharge.

OR

CASH PAY

- I, _____, consent to physical therapy services performed by the staff of Kinetic Physical Therapy Associates and am forgoing the use of health insurance, therefore will be paying $_____ out of pocket each visit, due at the conclusion of treatment. Any remaining balance will be due at the date of discharge.

Patient Signature: _____ Date: _____

Staff Signature: _____

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HIPAA – Release of Information

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination performed, treatment rendered to me, appointment scheduling, and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is **NOT** to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Contact by calling my:

[ ] Home: _____

[ ] Cell: _____

[ ] Work: _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Legal Representative or Patient Signature: _____ Date: ____/____/_____

Name and Signature of Witness:_____ Date: ___/____/_____

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Attendance Agreement

In order to maximize the benefits of therapy, it is very important that scheduled appointments be attended. The consistency of attending therapy sessions gives you the best opportunity to obtain maximum treatment benefit, and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and other patients.

In signing this form, you are indicating that you understand the attendance policy and the results of not keeping your appointments. We anticipate that you will adhere to the following:

- I understand that if I arrive fifteen minutes late, I may not receive therapy that day, depending on what the therapist's schedule is and that the appointment can be rescheduled for a time/date that fits within the upcoming schedule
- I understand that three "no-shows", within a treatment plan of care, are grounds for discharge from therapy. The physician or referring provider will be notified of my failure to show for appointments and the resulting discharge from therapy.
- I understand that if my regular therapist is not available, I could be given the option to see another therapist if one is available.

Following these guidelines will greatly assist in maintaining the flow of the clinic and allow clinicians to provide optimal care to all patients.

Patient/Guardian Signature _____ Date _____

PATIENT HISTORY FORM

Name: _____ **Height**: _____ **Weight**: _____

Are you **pregnant** or think you could? [ ] **YES** [ ] **NO**

Do you have a **pacemaker**? [ ] **YES** [ ] **NO**

Have you **fallen** within the past year? [ ] **YES** [ ] **NO**

Medical/Surgical History - Please check if you have ever had or currently have:

*Musculoskeletal	*Neuromuscular	*CardioPulmonary	*Other
__ Arthritis (Osteo/Rheumatoid)	__ Stroke/TIA	__ Heart Attack	__ Cancer
__ Osteoporosis	__ Head Injury	__ Hypertension	__ Diabetes/Hyperglycemia
__ Fractures or Broken Bones	__ Parkinson Disease	__ Heart Disease	__ Hypoglycemia
__ Low Back Pain or Surgery	__ Fibromyalgia	__ COPD	__ Infections/Infectious Disease
__ Joint Pain	__ Nerve Pain	__ Lung Disease	__ Autoimmune
__ Bone or Joint Surgery	__ Seizures	__ Vascular Problems	_____

Please list surgeries and the dates performed:_____

_____

Please list all current medications (you can also provide a list that we can scan into your e-chart):

_____

Please rate your pain MOST of the time over the past week if:

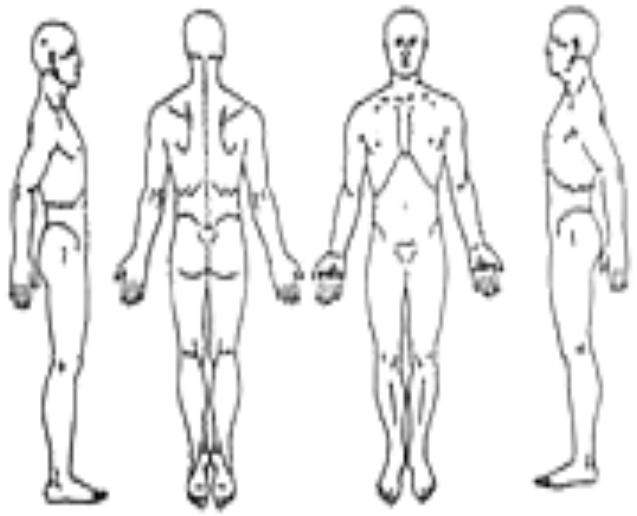
0 = no pain ---10 = worst pain imaginable

(Circle pain rating below)

0 1 2 3 4 5 6 7 8 9 10

Indicate areas of pain, tightness, numbness,

or tingling on the diagram.



Briefly describe the reason for your visit to physical therapy:

_____

Please list anything you have found that aggravates, or makes your pain/symptoms worse:

_____

Please list anything you have found that eases, or makes your pain/symptoms less:

_____

Have had any diagnostic tests such as x-rays, MRI, ultrasound, bone scans, etc…?_____