KINETIC
PHYSICAL THERAPY

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**

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 payment of insurance benefits to be made directly to Chambers Outpatient Rehab Services dba 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: ________________________

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: ___/____/______

Name: ______________________________________

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:____

____

Provide a copy of your medication list for us to scan in, or list known medicines:

____

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

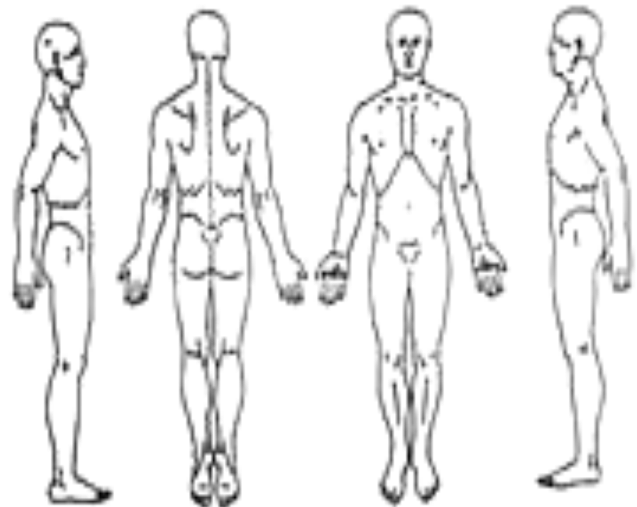
0 = no pain ---10 = worst pain imaginable

(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:

____