Patient Name____ Primary Language___________

Onset Date________________________________ **Surgery Date**__________________________

Describe Your Current Problem and How it Began____
____

Is this? [] Work Related [] Auto Related [] N/A

Goals with treatment:
Please check all the following that apply to you:
[] Avoid Surgery [] Education [] Return to Activities
[] Increase Function [] Increase Strength [] Decrease Pain
[] Other ____

Describe the nature of your pain:
[] Sharp [] Dull Ache [] Numb [] Shooting [] Burning [] Tingling

Current complaint (how do you feel today?)
No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Have you had x-rays, MRI, CT Scan for your area(s) of complaint: [] Yes [] No
Date(s) taken__________________________ **What areas were taken?**____________________

____

In general would you say your overall health right now is:
[] Excellent [] Very Good [] Good [] Fair [] Poor

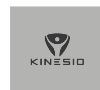
Please check all of the following that apply to you:
[] Alcohol/Drug Dependence
[] Recent Fever
[] Diabetes
[] High Blood Pressure
[] Cardiac Condition
[] Stroke (Date)____________________
[] Dizziness/Fainting
[] Cancer/Tumor (Explain)________________
____
____
[] Osteoporosis
[] Other Health Problems (Explain)_________
____

[] Numbness (Location)___________________________
[] Urinary Problems
[] Currently Pregnant, # Weeks____________________
[] Abnormal Weight [] Gain [] Loss
[] Pain Unrelieved by Position or Rest
[] Pain at Night
[] Surgeries____
____
[] Tobacco Use - Type_______________________________
Frequency__________________________________
[] Current Medications______________________________
____

____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give my authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature__________________________ **Date**__________



Kinesio Physical Therapy and Performance

Patient Information

Patient Name: ____

Address: ____

City: ____________________ **State:** ______________ **Zip:** ______________

Contact information for appointments, billing, and updates

Email: ______________________________ **Cell #** ____________________

Home #______________________ **Work #**______________________

Social Security: ______________ **Date of Birth:** ____________ **Age:** _____ **Sex:** _____

Emergency Contact: ____

Telephone #__________________ **Relation to Patient:** ______________________

Employment Status: Full Time/ Part-time/ Unemployed/Retired/ Full time student/Part-time student

Are you currently on Workman's Compensation benefits? YES / NO If yes, please provide the following

Employer: ____________________ Occupation: ______________________________

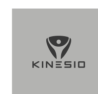
Address: ______________________________ Phone: ____________________

City, State: ______________________________ Supervisor: ____________________

❖ ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this, you acknowledge receipt of the Notice of Privacy Practices of Kinesio Physical Therapy and Performance. Our Notice of privacy provides information about how we may use and disclose your protected health information.

SIGNED: ____ DATE: ____________________



Kinesio Physical Therapy and Performance

Consent to Therapeutic Procedures

I, ______________________________, hereby consent to the therapeutic procedures outlined below, to be performed by Kinesio Physical Therapy and Performance.

_______ Evaluation and treatment of nerve, muscle, and skeletal dysfunction and/or pain
_______ Evaluation and treatment of functional loss
_______ Other: ____

These procedures have been explained to me in terms that I can understand and include the following about the proposed evaluation and treatment.

1. The nature and extent of the evaluation procedure to be performed
2. Any risks involved, if any, in evaluation or treatment
3. Treatment may include, but is not limited to:
   a. Joint and soft tissue mobilization
   b. Exercise including stretching, strengthening, and balance/coordination training in the clinic. Home exercises will be developed and given in writing if requested.
   c. Functional retraining and including postural and body mechanics training, gait training, and other lost functions that will be identified in the evaluation process
   d. Modalities such as heat, ice, electrical stimulation, iontophoresis, and ultrasound.
   e. Special procedures such as taping, orthotics, and neuromuscular electrical stimulation.

-If home exercise equipment such as exercise bands, foam rollers, or exercise balls are prescribed by my therapist, I understand that I may purchase them from this facility or obtain them from other sources.
-I understand that I may consult with other therapists and/or physicians at any time regarding my condition, and I have the right to refuse any therapeutic procedures and treatment at any time.
-Any questions I thought were important in deciding whether or not to undergo evaluation treatment have been answered to my satisfaction. I understand I may ask additional questions at any time.
-I understand no assurance of a successful outcome or guarantee of success has been given to me.
-I certify that I have read the above consent statement, that I understand the explanation of procedures, and that this consent is given freely, voluntarily, and without reservation.

______________________________________ ______________
Patient or Responsible Party Signature Date

______________________________________ ______________
Physical Therapist Signature Date

Kinesio Physical Therapy and Performance

Acknowledgement Form For Explanation of Benefits

Patient Name: ____ DOB: ________________________

Effective Date: ____________________________________ In/Out Network: _______________________

Deductible Met/Not Met: ________________________ Remaining Balance: ___________________________

Patient is responsible for the full contracted rate until deductible i met. An estimated amount will be collected up front based on your contract rates with your insurance carrier (please note: because an estimated amount is collected, you may be billed for the difference).

Physical Therapy Benefits:

Primary Insurance: ________________________________ Id Number: _________________________________

Co-Pay: ______________ Coinsurance: ________________ Limitations: _________________

Additional information: ____

Secondary Insurance: _______________________________ Id Number: ________________________________

Co-Pay: ______________ Coinsurance: ________________ Limitations: _________________

Additional information: ____

Kinesio Physical Therapy's At Time of Service Prices:

Initial Evaluation: $150.00 **Follow Up Visits: $75.00**

ALL COPAYS, COINSURANCES, OR DEDUCTIBLES ARE DUE AT TIME OF SERVICE

It has been explained and I understand in full details the Kinesio Physical Therapy and Performance benefits according to my insurance carrier ____.

I, ____ understand and agree that it is my responsibility to ask about any accumulated fee before and/or after services that have been rendered. I understand and agree that if my insurance contract is terminated and/or canceled during the time I am in the Physical Therapy program, it is my responsibility to bring Kinesio Physical Therapy and Performance new proof of insurance so the new benefits can be explained. If I do not provide any new insurance, I understand and agree that I am responsible to pay Kinesio Physical Therapy and Performance 100% out of pocket for the services rendered.

ASSIGNMENT OF BENEFITS

1. It is customary to pay for professional services when rendered. If you cannot settle your account at the time of each office visit, special arrangements must be made in advance with our office.
2. Patients who have Health Care Insurance should understand that charges for professional services are charged to the patient and not to the insurance company. Payment for charges incurred is the responsibility of the patient or the parent of the patient, if the patent is a minor.
3. Our office will be happy to bill your insurance carrier for you. However, we cannot accept responsibility for collection from your insurance carrier or for negotiating a settlement of a disputed claim. I hereby authorize Kinesio Physical Therapy and Performance to furnish information to insurance carriers concerning this treatment and I hereby adding all payment for services rendered.

Signed: ____**Date:** _________________________

Kinesio Physical Therapy and Performance

<u>Welcome Letter</u>

Dear Patient,
Welcome to Kinesio Physical Therapy and Performance. We are excited about helping you move better. Please let us know if you have any questions or comments, as we value and appreciate your opinion. Please review the following guidelines below, about the financial aspect of our relationship before we start your treatments. We hope this minimizes any miscommunications.

1. We will check your benefits before or during your first appointment. If there are any deductibles that need to be met you will be charged our at time of service prices until the deductible is met. Our at time of service prices are as followed:
    a. **Initial Evaluation- $150.00**
    b. **Follow up Appointments- $75.00**

2. Cancellations must be done 24 hours prior to scheduled appointments. If you fail to cancel in a timely manner, you are subject to a $50.00 cancellation fee. The same fee applies for missed appointments.

3. There will be a $25.00 fee for any returned checks.

4. We ask all Medicare patients to schedule a medical doctor appointment every 30 days while they are receiving outpatient physical therapy and obtain a prescription. This rule is in accordance with Medicare guidelines and to insure reimbursement for our services rendered, failure to do so may result in the patient paying for their treatment.

5. Please arrive promptly for your scheduled appointment time. Being tardy may decrease your one on one time with the therapist and may potentially require your appointment to be rescheduled.

We thank you for choosing Kinesio Physical Therapy and Performance as your rehabilitation clinic. We look forward to helping you during your road to recovery.

I agree to the above statements and if applicable, will fulfill my obligations accordingly.

____ ________________________
Signature Date

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by your name. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine/voicemail box? YES NO

May we discuss your medical condition with any member of your family? YES NO
If YES please name the members allowed:

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: ________________

Witness: ____ Date: _________________