KINESIS POWERED BY MOUNTAIN RIVER PHYSICAL THERAPY

Patient Information

Patient Name: _____ Social Security #: _____

Address (Street):_____ Birthdate: _____ Sex: ❒ Male ❒ Female

Home Phone: _____ Cell Phone: _____ Work Phone:_____

** Message and Data Rates May Apply, see your carrier for details.

Marital Status: ❒ Single ❒ Divorced ❒ Married ❒ Widowed

Employer: _____ Employer Phone: _____

Employer Address:_____

Person Responsible for Account Payment

If person responsible for payment is different from patient, please complete below:

If patient is a child please indicate if parents are: ❒ Married ❒ Separated ❒ Divorced

Name: _____ Social Security:_____

Address (Street):_____ Birthdate:_____

Address (City, Street, Zip): _____ Phone #: _____

Referral Information

Primary Care Physician: _____ Referring Physician:_____

Accident Information

Is your injury the result of an accident? ❒ Yes ❒ No If so, please complete the section below. ____

Date of Accident: _____ How did it happen? ❒ Auto ❒ Work ❒ Other

State in which injury occurred? _____ Insurance Company:_____

Claim #: _____ Claims Adjuster: _____ Phone: _____

Address:_____

Name of Attorney:_____ Phone: _____

Emergency Information

In case of emergency notify – Name: _____ Relationship: _____

Address: _____ Phone: _____

Insurance Information

Primary Insurance		**Secondary Insurance**	
Insurance Name		Insurance Name	
Policy/ID #		Policy/ID #	
Group/Account #		Group/Account #	
Policy Holder's Name		Policy Holder's Name	
DOB		DOB	
Social Security #		Social Security #	
Relation to Patient		Relation to Patient	

Notification of Patient Responsibility

Kinesis Physical Therapy verifies your benefits with your insurance carrier but does not guarantee any information given to us regarding benefits, authorization or network plan. We request that you check with your health insurance plan for a complete understanding of what will be billed to you. If the information provided by your insurance company or by you is not accurate or the insurance company changes its coverage, you will be responsible for payment for services.

Based upon the information that your insurance company quoted to us, your benefits are as follows:

Deductible: _____ Co-Insurance: _____ Co-Pay:_____

Benefit Description: _____

Do you have an HRA or HSA? _____

Financial Responsibility and Assignment of Benefits

I understand that insurance billing is provided as courtesy and that I am financially responsible to Kinesis Physical Therapy for all charges arising from my treatment. * We do not bill tertiary carriers. It is my responsibility to notify Kinesis Physical Therapy for any changes in my health care coverage. While Kinesis Physical Therapy verifies benefits with my health plan, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as worker's compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases or any other type of information necessary to allow for speedy collection from my third-party payor. I understand that if I have a remaining balance after 60 days my account may be placed with an outside collection agency. * We accept payment by cash, check, Visa, MasterCard or Discover.

Notice of Privacy Practices

I hereby acknowledge that I have received or declined a copy of the Notice of Privacy Practices for Kinesis Physical Therapy. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Cancellation Policy

Appointment times are reserved exclusively for you. If you are unable to keep your appointment, we request 24 hours' notice to allow us time to offer that appointment to someone else. We do understand that extenuating circumstances sometimes occur for missing appointments and should be discussed with the office manager.

Medicare Patients

You may not access Home Health Agency benefits and attend our clinics during the same period of time. You will be re-evaluated by your physical therapist every 10 visits. Due to Medicare's requirements, we will contact your referring physician to provide a new referral to our office every 90 days as needed. If we do not receive a new referral from your physician as required, Medicare may deny payment of services and you could be financially responsible for therapy provided outside of the referral dates or we may be unable to continue treatment until a new referral is received. We will bill your secondary insurance if applicable. However, you are responsible for the deductible if it has not been met at the time of service, and the co-insurance if there is no secondary insurance.

Are you currently receiving home health? ❒ Yes ❒ No If yes, last date of service and name of Home Health Agency: _____

Have you received PT, OT, or Speech Therapy services since January 1 of this year? ❒ Yes ❒ No

Medical History

Age:_____ Height: _____ Weight: _____

1. How would you rate your general health? ❒ Excellent ❒ Average ❒ Poor ❒ Good ❒ Fair
2. How often do you exercise outside of normal daily activities?

   ❒ 5+ days/wk. ❒3-4 days/wk. ❒ 1-2 days/wk. ❒ Occasionally ❒ Zero

3. Do you drink caffeinated beverages? ❒ Yes ❒ No ❒ Cups/day:_____
4. Do you smoke? ❒ Yes ❒ No ❒ Packs/day:_____
5. What is your stress level? ❒ Low ❒Medium ❒ High
6. Are you pregnant? ❒ Yes ❒ No
7. Do you have a pacemaker? ❒ Yes ❒ No
8. Have you been bothered by feeling down, depressed or hopeless? ❒ Yes ❒ No
9. Have you been bothered by having no interest or pleasure in things? ❒ Yes ❒ No
10. Is this something you would like help with? ❒ Yes ❒ No ❒ Not today

Medications:

Please list all current prescriptions and over the counter supplements taken (Additional space to list medication available upon request.

_____

_____

Please list any allergies to medications.

_____

_____

Past Medical History

Have you ever had/been diagnosed with any of the following conditions?

❒ Angina/Chest Pain	❒ Drug/Alcohol Abuse/dependency	❒ Heart Problems
❒ High Blood Pressure	❒ Heart Attack	❒ Blood Disorders
❒ Stroke	❒ Tumor	❒ Circulatory Problems
❒ Cancer	❒ Anemia	❒ Asthma
❒ Kidney Problems	❒ Lung Problems	❒ Gout
❒ Bone/Joint Infection	❒ Osteoporosis	❒ Osteoarthritis
❒ Stomach Problems	❒ Bladder Infections	❒ Diabetes
❒ Rheumatoid Arthritis	❒ Neck Injuries	❒ Back Injuries
❒ Joint Sprains	❒ Fractures/Broken Bones	❒ Jaw Injuries/TMJ
❒ Muscle Strains	❒ Dislocations	❒ Epilepsy
❒ Liver Problems	❒ Multiple Sclerosis	❒ Allergies
❒ Autoimmune Disease	❒ Pelvic Inflammatory Disease	❒ Pneumonia
❒ Thyroid Problems	❒ Nervous/Emotional Problems	❒ Whiplash

❒ Infectious Disease (Hepatitis, Tuberculosis, etc.) ❒ Other: _____

Surgery:

Have you had any surgeries in the past? ❒ Yes ❒ No

If yes, please list type and date of surgery:_____

_____

Work History:

Are you currently working? ❒ Yes ❒ No

If yes, what is your job title and description:

_____

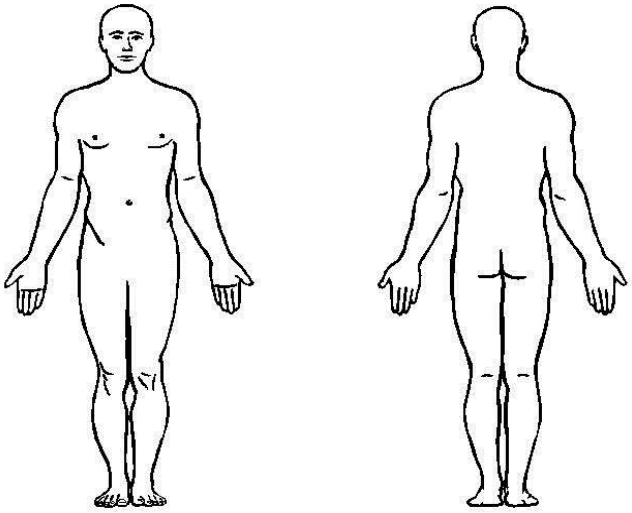
_____

If no, when did you last work? : _____

History of Present Condition:

1. What are you symptoms?
   _____
   _____
   _____
2. When did your symptoms begin?
   _____
3. How did your symptoms begin?
   ❒ Gradually ❒ Suddenly

- Please indicate on the body chart where your symptoms are localized.



3. What do you think caused your symptoms?
   _____
   _____
   _____

5. Since onset, how are you symptoms?
   ❒ Better ❒ Worse ❒ Same

6. Have you been treated for this problem in the past? ❒ Yes ❒ No
   - If yes, what kind of treatment did you receive?
     ❒ Physical Therapy ❒ Chiropractic ❒ Other: _____

7. Describe your symptoms:
   ❒ Constant ❒ Decreasing ❒ Sharp Pain ❒ Intermittent
   ❒ Static ❒ Dull/Achy Pain ❒ Occasional ❒ Night Pain
   ❒ Pain Upon Walking ❒ Increasing ❒ Stiffness ❒ Other: _____

8. What aggravates your symptoms?
   _____

9. What relieves your symptoms?
   _____

10. On a scale from 0-10, with **0 being no pain and 10 being the worst pain**, how would you rate your average pain in the past 24 hours? _____

11. Have you had any of the following tests?
    ❒ X-Rays ❒ MRI ❒ CT Scans ❒ EMG/NCV

Parental Consent

We understand that divorced parents and legal guardians other than the child's parents have special circumstances. We don't want your child's health to be neglected because of these situations. Therefore the legal guardian who brings the child in for the appointment is responsible for payment.

In case the parent and/or legal guardian will not be picking the child up from their appointment, the people listed below are whom we are allowed to release the child to.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

This consent serves as permission for treatment of my child by Kinesis Physical Therapy. I agree to pay for all services provided to my child.

_____ _____

Parent/Gaurdian Date

_____ _____

Witness Date

Consent for Treatment and Release of Information

I am aware of my diagnosis and wish to receive treatment from Kinesis Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Kinesis Physical Therapy to release information, verbal and written, contained in my medical record and other related information to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Kinesis Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

All medical records will be kept on file in our office for a ten (10) year period prior to destroying.

Please tell us how you learned of our service or whom we can thank

- ❑ I was a **Former Patient**
- ❑ **Family/Friend/Co-Worker** Recommendation
- ❑ MRPT **Brochure**
- ❑ **TV/Billboard** Advertisement
- ❑ Clinic **Sign**
- ❑ **Radio** Advertisement
- ❑ **Former Patient** Recommendation
- ❑ **Doctor** Recommendation
- ❑ Found you on the **Internet**
- ❑ **Publication/Newspaper** Advertisement
- ❑ Saw you at an **Event**
- ❑ Other _____

I certify that I have read this agreement and my signature indicates my understanding and consent.

Signature:_____ Date:_____