Medical History

Date:_____ **Name:** _____

DOB:_____ **Age:**_____ **Height:** _____’_____’’ **Weight**: _____ lbs**.**

I am here today because: _____

Date of Injury/Onset:_____ **Cause:** ☐ Auto ☐ Work ☐ Sports ☐ Unknown ☐ Other _____

Relevant Surgery Date(if applicable):_____ **Describe:**_____

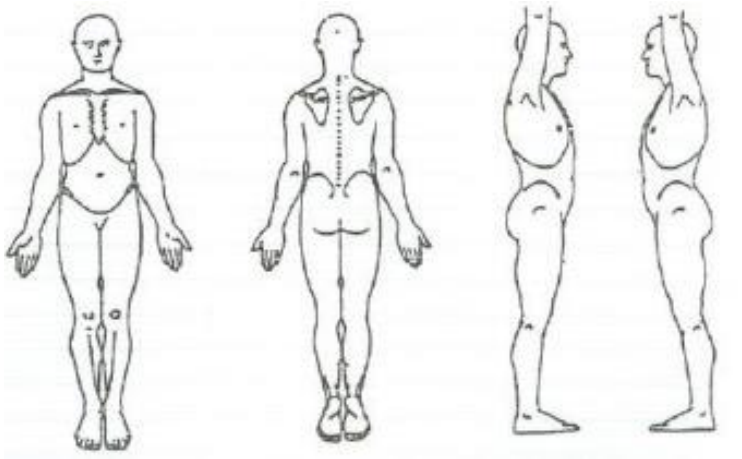
Other Surgical History: _____

Current Meds (if medicare fill out separate med list): _____

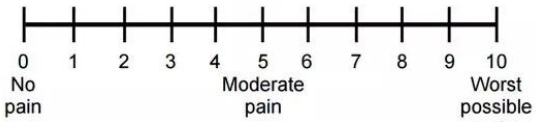
Relevant X-Rays: _____ **CT–Scan:** _____ **MRI:** _____ **Other:** _____

USING THE DIAGAM INDICATE WHERE YOU ARE EXPERIENCING SYMPTOMS

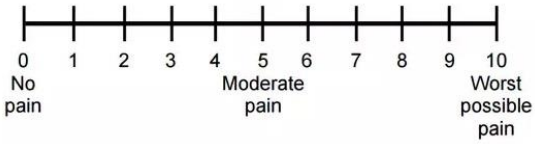
XXX = Pain ///// = Numbness/Tingling



AVERAGE PAIN INTESITY: Past week



WORST PAIN INTENSITY: Past week



How often do you experience symptoms:

☐ Constantly: (76 -100% of the time)
☐ Frequently: (51-75% of the time)
☐ Occasionally: (26-50% of the time)
☐ Intermittently: (0-25% of the time)

How much have your symptoms interfered with your usual daily activities?

☐Not at all ☐ A little bit ☐Moderately ☐Quite a bit ☐ Extremely

Please select or describe any prior treatments or self-care for this condition:

☐Chiropractic ☐Heat ☐Cold ☐Exercise ☐Physical Therapy ☐Injections
☐Other_____

Please select or describe what you want to accomplish from therapy (Your Goals/Limitations):

☐Improve sleep ☐Decrease pain ☐Sitting/Standing ☐Reaching/Lifting ☐ Recreation
☐Stairs ☐ Walking ☐Other _____

Are you currently working? ☐Yes ☐No **Restrictions?** ☐Yes ☐No
Employer _____ **Hours/Week:** _____

Medical History

Please check the box next to any of the following you experience, if you have been diagnosed with the condition, or if the symptom/status applies to you.

General Health:

- ☐ Current Smoker
- ☐ Pregnant (or potentially)
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Respiratory Problems
- ☐ Asthma
- ☐ Hepatitis
- ☐ Seizures
- ☐ Osteoporosis
- ☐ Kidney Problems
- ☐ Stroke
- ☐ Concussion
- ☐ Depression
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Pacemaker
- ☐ Metal Implants
- ☐ Circulation Problems
- ☐ Stomach Ulcers
- ☐ Recent Nausea/Vomiting
- ☐ Hearing Problems/Loss
- ☐ Infectious Diseases (HIV, Hepatitis, TB, etc…) _____
- ☐ Other: _____

Head/Jaw/Neck:

- ☐ Facial Pain
- ☐ Experience a click or pop when you open or close your mouth
- ☐ Weekly headaches
- ☐ Pain in the front of your ear
- ☐ Ear "fullness" or "ringing"
- ☐ Wake up with a dry mouth
- ☐ Tension at the base of your skull when you turn your head in the upright position
- ☐ Previous braces, retainers, or dentures
  if so, when? _____
- ☐ Currently wear mouth appliance or retainer

Breathing:

- ☐ Snoring
- ☐ Diagnosed with sleep apnea
  - ☐ Use CPAP or Mouth Splint
- ☐ Difficulty breathing with simple activities (i.e. going up steps)
- ☐ Feel tired after a full night of sleep
- ☐ Use an inhaler
- ☐ Have to sleep upright

Feet:

- ☐ Flat Feet
- ☐ Pain on the bottom of your feet when you are standing
- ☐ Large bony bump near either of your big toes
- ☐ Use orthotics/heel lifts/other foot inserts in shoes
- ☐ One foot turns out more than the other
- ☐ Feel unstable with one or both ankles
- ☐ 1 or more ankle sprains
  - ☐ Right ankle ☐ Left ankle

Vision:

- ☐ Wear contacts
- ☐ Wear glasses
- ☐ Wear bifocals/progressive lenses
- ☐ Occasionally bump into objects while walking
- ☐ Difficulty driving at night
- ☐ Blurry/double vision
- ☐ Dizziness
- ☐ Have astigmatism
- ☐ History of lazy eye
- ☐ Lasik surgery,
  if so, when? _____

Lumbo/Pelvic/Femoral:

- ☐ Small amounts of urine leakage with coughing, sneezing, laughing, lifting, or exercising
- ☐ Small amounts of urine leakage associated with a strong sensation of needing to go to the bathroom
- ☐ Frequent trips to the bathroom that disrupt your day or needing to plan trips out based on where the bathrooms are
- ☐ Frequently strain to have a bowel movement or empty your bladder
- ☐ Pain, discomfort, or pressure in the pelvic area when sitting or standing of prolonged periods of time

List any other issues/concerns you would like us to know about: _____

_____

_____

_____

_____

Patient Registration

Today's Date: _____

PATIENT INFORMATION:

Last Name: _____ First Name (Legal): _____ Preferred Name: _____

DOB: _____Birth Sex: _____ Gender Identity:_____ Preferred Pronouns: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____

What type of appointment reminders do you want? ☐ VOICE ☐ TEXT to what number? ☐ HOME ☐ CELL

E-mail Address (for clinic communication only): _____

Emergency Contact Name: _____ Relationship: _____ Phone : _____

Financial Responsibility Name, Relationship, DOB Address & Phone (if not patient): _____

_____

Referring Provider: _____ Referring Clinic: _____

Primary Care Provider: _____ Primary Care Clinic: _____ Date last seen: _____

How did you hear about our clinic? ☐ Website ☐ Search Engine ☐ Doctor ☐ Brochure ☐ Other: _____

PRIMARY INSURANCE BENEFITS:

Insurance: _____ Member ID # : _____ Group # : _____ Medicare Plan? ☐ Yes

Policyholder Info (if not patient): Name: _____ DOB: _____ Relationship to patient: _____

SECONDARY HEALTH INSURANCE (if applicable):

Insurance: _____ Member ID # : _____ Group # : _____ Medicare Plan? ☐ Yes

Policyholder Info (if not patient): Name: _____ DOB: _____ Relationship to patient: _____

WORKERS COMPENSATION, AUTO ACCIDENT, OR PERSONAL LIABILITY (if applicable):

How were you injured? ☐ Work ☐ Auto ☐ Liability Claim or File #: _____ Injury/Accident Date: _____

Adjustor Name: _____ Adjustor Phone: _____ Ext.: _____

Work Comp/Auto/ Liability Insurance Name: _____ Phone: _____

Insurance Address : _____

Signature of Patient or Legal Guardian: _____ **Date:** _____

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual and attach legal documentation of your authority:

☐ Legal Guardian ☐ Power of Attorney ☐ Other_____

Please read each section below and initial next to each one to signify understanding and agreement. If applicable, legal guardian must initial

Patient Consent

(to be updated yearly)

_____ **RECORDS RELEASE:** I hereby authorize the release of any information by Kinetic Physical Therapy Institute, Inc. to my referring doctor and insurance company. Furthermore, I authorize the release of any information from my referring doctor to Kinetic Physical Therapy Institute, Inc.

_____ **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE, PRIVACY PRACTICE (HIPPA):** I hereby acknowledge that I was able to view a copy of this medical practice's Notice of Privacy Practices (posted near front desk) and given the opportunity to request a copy of this document. If I requested a copy, I acknowledge that I received a copy.

_____ **MEDICALLY INFORMED CONSENT:** I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at Kinetic Physical Therapy Institute. It is the clinic's sincere intent to educate me on every process from billing to treatment and eventually discharge me from services. Therefore, if techniques that are being used to retrain, recruit, and restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objects and outcomes are, and how he/she is trying to achieve them. This consent shall be ongoing for one (1) year.

_____ **CANCELLATION/NO SHOW POLICY:** I acknowledge that I read and understand the Cancellation/No Show Policy and agree to abide by its terms and conditions. **I acknowledge that I may be charged $30 per No Show or Late-Notice Cancellation**. I acknowledge that I need to request a hard copy of this policy if I want one for myself.

_____ **Assignment of Benefits/Financial Responsibility:** I hereby authorize my insurance benefits be paid directly to Kinetic Physical Therapy Institute, and understand that I am financially responsible for non-covered services. I understand that if Kinetic Physical Therapy does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize Kinetic Physical Therapy Institute to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge. **I am responsible for all charges incurred at Kinetic Physical Therapy Institute.**

_____ I understand that it is my responsibility to check that my insurance has physical therapy benefits and that Kinetic Physical Therapy Institute is in-network. Any costs that my insurance does not cover because of network status or lack of physical therapy benefits will be my responsibility to cover.

_____ I understand that I may not receive a statement of payments due between visits, but that I will still be expected to pay any amount due at the time of my next visit. Furthermore, I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in the status of my personal or medical information.

_____ **MEDICARE AUTHORIZATION (for Medicare Patients Only):** I request that payment of authorized Medicare benefits be made to me or on my behalf to Kinetic Physical Therapy Institute, Inc. for any services furnished to me by that clinic. I authorize any holder of my medical information released to the health care financing administration services. I permit a copy of this authorization to be used in place of the original. I hereby authorize Kinetic Physical Therapy Institute, Inc. to treat as prescribed.

I hereby authorize Kinetic Physical Therapy Institute, Inc. to treat me and/or my dependent. I have read and understand all of the foregoing.

Signature of Patient or Legal Guardian: _____ **Date:** _____

Printed Name of Patient or Legally Authorized Representative _____

If representative, specify relationship to the individual and attach legal documentation of your authority:

☐ Legal Guardian ☐ Power of Attorney ☐ Other_____

Physical Therapy Institute

Payment Policy

<u>Supplies or other fees</u> not covered by your insurance are due at the time medical services are rendered

Please check the box if any of the following apply to your current insurance plan:

☐ **Self-Pay:** If you choose to not bill your visit through an insurance company, you are **required to pay in-full** at the end of your visit. You will receive a **30% discount** to the services when paid on the same-day.

☐ **Co-payments:** Co-pays are **due at check-in** for every visit, until your Out of Pocket Maximum is met. We try to determine the appropriate co-pay amount based on your insurance card; however, the amount may be different once your insurance processes your claim. Any additional amount will be due at your next visit/upon receipt of statement.

☐ **$500+ Deductible:** Patients who have insurance with a deductible of $500 or more **are required to pay a minimum of $100 each visit**. This payment will be go towards your balance once the claim has been processed by your insurance company.

- **HealthPartners** plans with deductibles are asked to pay **$120** each visit, which is the full cost of the visit (apart from supplies/etc) once your insurance plan makes their adjustments
- These payments will all be applied to your deductible and you will be refunded for any overpayments or they will be applied to future visit costs

☐ **Out of Network Plans:** Typically these plans require more patient responsibility. It is your responsibility to check on your coverage, as you will be responsible for any balances due. If your coverage is poor, you have the self-pay option as described above.

Previous balances are due at check-in and/or receipt of billing statement

You may or may not receive a statement before your next appointment with the amount due, please refer to the EOB from your insurance company for the most up-to-date information.

I have read and understand the above and agree to follow the payment policy as described above.

Signature of Patient or Legal Guardian: _____ **Date:** _____

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual and attach legal documentation of your authority:

☐ Legal Guardian ☐ Power of Attorney ☐ Other_____

If you would like to receive a copy of this policy, please see the front desk

Authorization to Release Protected Health Information (PHI) to Family Members or Designated Individuals

HIPAA Laws prevent us from discussing or disclosing your protected health information to family members, friends or other designated individuals unless you provide Kinetic Physical Therapy Institute with authorization to release this information. We are required to have a completed Authorization on file prior to releasing your protected health information**.**

DESIGNATION OF FAMILY MEMBERS, FRIENDS OR OTHER INDIVIDUALS

Please complete this form to designate the individuals(s) to whom we may release your Protect Health Information. Your Protected Health Information includes your medical and billing records maintained by Kinetic Physical Therapy Institute.

I, _____

Printed Name of Patient (First Name, Middle Initial, Last Name) Date of Birth

authorize Kinetic Physical Therapy Institute to disclose my protected health information to the individual(s) listed below:

Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient

I understand that this Authorization is voluntary and I may revoke my authorization in writing at any time, except to the extent that action has been taken by Kinetic Physical Therapy Institute in reliance on this authorization. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the individuals listed and no longer protected under federal Law.

I also understand that by signing this form all prior Authorizations to Release Protected Health Information to Family Members or Designated Individuals are null and void as of my signature date below.

Signature of Patient or Legal Guardian: _____ Date: _____

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual and attach legal documentation of your authority:

☐ Legal Guardian ☐ Power of Attorney ☐ Other_____

Physical Therapy Institute
KINETIC

Current Medication List

(Medicare Patients Only)

Patient Name: _____ DOB:_____

please list all tablets, patches, drops, ointments, injections, etc.. In addition, include prescription, over-the-counter, herbal, vitamin, and diet supplement products and anything that you take only on occasion (like albuterol, nitroglycerin, etc…)

Medication Name	Reason for Taking	Dosage	# of Time(s) of Day	Form (tablet, cap, etc…)