Kinetic Energy PT *New Patient Information*

Patient Name:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Physical Address:_____ City:_____ State:_____ Zip:_____

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

Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Email Address:_____ ☐ Please do not send me KEPT's quarterly newsletter

Referring Physician:_____ Diagnosis:_____

***How did you hear about us? ☐ MD ☐self ☐existing patient /friend ☐newspaper ☐website ☐other_____**

Date of Onset (injury, accident, surgery date or recent date symptom started):_____

Policy Holder Information (person financially responsible)

Name:_____ Relationship to patient:_____

Birth date:_____ Sex:_____ Social Security #:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

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

Insurance Information (to be completed by authorized Kinetic Energy PT employee: initial _____)

Company:_____ Phone:_____

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

Claim / Group #_____ Policy or ID #:_____

Co-Pay:_____ **Deductable**:_____ **MET?** Y or N **Referral Required?** Y or N **Pre-Auth Required?** Y or N

Coverage Details:_____

_____

Insurance Verifier Name: _____ Date:_____ Time:_____

Secondary Insurance: _____ Phone:_____

Policy # or ID: _____

Coverage Details: _____

Kinetic Energy Physical Therapy PC
Notice of Privacy Practices for Protected Health Information

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review this notice carefully. If you have any questions about it, please call KEPT at 970.879.8026.

Your Rights

Get a copy of your medical record
• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record
• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say "yes" to all reasonable requests.
Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
• If you pay for a service or health care item out-of- pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information
• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, we will provide you with a paper copy promptly.
Choose someone to act for you
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated
• You can complain if you feel we have violated your rights by contacting us at **Kinetic Energy Physical Therapy PO Box 883299 Steamboat Springs, CO 80488, 970.879.8026**
• You can file a complaint with **the U.S. Department of Health and Human Services Office for Civil Rights** by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877- 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:
• Marketing purposes
• Sale of your information
In the case of fundraising:
• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.
Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
How else can we use or share your health information?
We can share health information about you for certain situations such as:
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety

Our Responsibilities
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you.
The new notice will be available upon request, in our office, and on our web site.

KINETIC ENERGY
PHYSICAL THERAPY

Patient Financial Responsibilities

Thank you for choosing Kinetic Energy Physical Therapy. We consider it a privilege to provide your physical therapy care. From the moment you walk in the door until the time we regrettably have to say our goodbyes, we are committed to providing you with amazing service throughout your experience with us. In order to do so, we would like to offer the following information:

INSURANCE

We need accurate information about your insurance. Therefore, please have your current insurance card with you at all times. Please report any changes to your insurance coverage, demographics, etc. to us as soon as possible.

Kinetic Energy PT will verify your benefits and eligibility with your insurance company; we recommend that you do the same. All benefits are subject to medical necessity and do not represent a guarantee of payment by your insurance company.

CO-PAYS

We are required by our insurance contracts to collect all co-pay amounts at the time of service. We accept cash, check, Visa, and MasterCard. If you would like to limit the number of transactions, we do accept payment for the week in advance.

COINSURANCE

Coinsurance is an estimated percentage of an eligible expense that you are required to pay for a covered service. These details are specific to your individual plan; please call your insurance company for details.

DEDUCTIBLES

If you have not met your deductible we will arrange for payment with you after it is processed through your insurance company. Please note that other healthcare provider services are typically applied towards this deductable as well.

SELF-PAY PATIENTS

Initial evaluation (first visit) cost is $120.00 which includes treatment, all follow up visits are $80.00 per visit; payment is due at time of service. KEPT will not bill your insurance company and thus payment is not be applied to your deductible.

Medicare

A physician's referral is required specifying the **duration and frequency** for physical therapy. Maximum coverage is a combined benefit of $1980.00/year for physical and speech therapies. Secondary coverage **may** help to cover additional costs (please call your secondary insurance company for details).

STATEMENTS

Statements are sent monthly to the address provided. In the event of default, you will be referred to an outside agency for purposes of collection of unpaid balance.

***No-Show Policy:* You, as a patient at Kinetic Energy PT, are *personally responsible* for your appointments. We reserve the right, at our discretion, to charge a *$80 No Show fee* which is not billable to your insurance company. We greatly appreciate a 24 hour advanced notice for any cancellations.**

Consent to Physical Therapy

1. I have presented myself to this facility for physical therapy treatment and consent to diagnostic procedures and care provided by my attending physical therapist.
2. I understand that information from any medical record(s) kept by this facility may be used for educational administrative and/or facility approved purposes when my personal identity will not be revealed.
3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of services. I am responsible for any services not covered by my insurance plan.
4. **24 Hour Minimum Notice for Cancellation is Required**. If you wish to cancel your appointment we request you call 24 hours prior to your appointment so that we may schedule another patient at that time. We are considerate with your time, please be considerate with ours.
    - **$40 cancellation fee** may be applied to your account balance.
5. **No-Show Policy:** You, as a patient at Kinetic Energy PT, are personally responsible for your appointments.
    - **$80 no show fee will automatically be charged to your account balance** If you do not show up for an appointment and do not call

I have read, fully understand and will comply with the above policies and any questions I may have had have been answered to my satisfaction.

◯_____

Print Name of Patient (or Parent if Patient is a minor – under 18)

◯_____

Signature of Patient (or Parent if patient is a minor – under 18) Date

Notice of Privacy Practices for Protected Health Information (HIPPA)

I have read, understand and agree with the HIPPA Privacy Policy presented by Kinetic Energy Physical Therapy, PC.

◯_____ **initial**

Communication via PLAIN Email and Texting

Yes, I would like to receive information regarding my care, appointments and response to questions from my physical therapist/KEPT staff utilizing:

_____ plain text: Phone # _____ (carrier charges may apply to your account)

_____ plain email : _____

**I understand the inherent risk that plain email and texting are not secure and accept that this communication can be compromised.

◯_____ **initial**

Musculoskeletal Pain Diagram

Name: _____Date: _____Age:_____
Gender:___Occupation:_____Hobbies/Sports_____

Current Symptoms:

1) Where are you currently experiencing symptoms?_____
2) What date (roughly) did the symptoms begin?_____
3) Did your pain begin □ Gradually? □Suddenly? □ By Injury?
   Explain:_____
4) Have you had this problem before? □ YES □ NO If yes, when?_____
5) What aggravates your symptoms? □Sitting □ Rise from Sitting □ Standing □ Lying Down □ Lifting □ Overhead Activity □ Bending □ Walking □ Running □ Stairs □ Squatting □ Kneeling □ Jumping Coughing/Sneezing □Other:_____
6) What eases your symptoms?_____
7) My goal for physical therapy is:_____
8) Please circle any treatments you think may help you: Stretching/Strengthening Heat/Ice Dry Needling Joint mobilization/manipulation/"popping" Massage/Soft tissue Electrical Stimulation Unsure Other_____

Please rate your pain over the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

Please rate your pain at it's best:

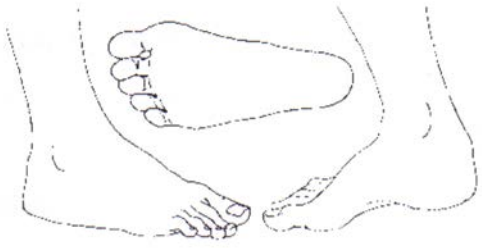
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

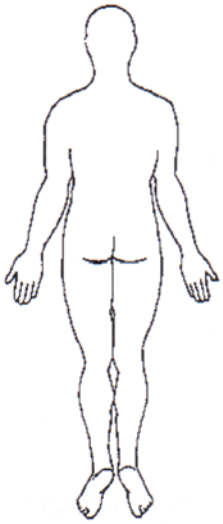
Please rate your pain at it's worst:

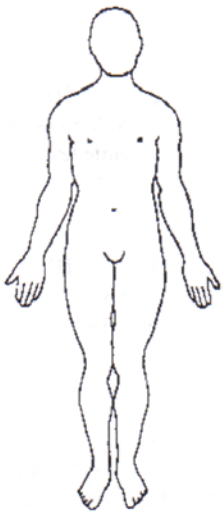
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

Please draw your areas of complaint using the diagram and the markings below:

ACHE	BURNING	NUMBNESS	PINS/NEEDLES	THROBBING	OTHER/GENERAL
^^^^^	========	0000000000	……..	//////////////////	xxxxxxxxxxxxxxx







Name: _____ Height _____ Weight_____

Have you or an immediate family member been diagnosed with any of the following:

	Self	Family
Cancer	Yes…No	Yes…No
Diabetes	Yes…No	Yes…No
High Blood Pressure	Yes…No	Yes…No
Heart Disease	Yes…No	Yes…No
Angina/Chest Pain	Yes…No	Yes…No
Stroke	Yes…No	Yes…No
Osteoporosis/Osteopenia	Yes…No	Yes…No
Arthritis	Yes…No	Yes…No
Allergies/Asthma	Yes…No	Yes…No
Kidney/Urinary Disease	Yes…No	Yes…No
Sexually Transmitted Disease	Yes…No	Yes…No
Seizures	Yes…No	Yes…No
Rheumatoid Arthritis	Yes…No	Yes…No
Depression	Yes…No	Yes…No
Blood Clots	Yes…No	Yes…No
Blood Borne disease	Yes…No	Yes…No
Bleeding Disorder	Yes…No	Yes…No
Abnormal Cholesterol	Yes…No	Yes…No

Have you *recently* had, or are you *currently* experiencing any of the following:

A change in your health	Yes…No
Nausea, Vomiting, or Diarrhea	Yes…No
Fever/Chills/Sweats	Yes…No
Unexplained weight change	Yes…No
Numbness or tingling	Yes…No
Changes in appetite	Yes…No
Difficulty swallowing	Yes…No
Bowel/bladder changes	Yes…No
Difficulty breathing	Yes…No
Dizziness	Yes…No
Infection	Yes…No
Change in your balance	Yes…No
Pain at night	Yes…No
Excessive Fatigue	Yes…No
Incontinence	Yes…No
Rashes or skin irregularity	Yes…No
Headache	Yes…No
Difficulty with hearing	Yes…No
Difficulty with vision	Yes…No
Difficulty with speech	Yes…No
Use of steroid medications	Yes…No

Do you or have you smoked tobacco? Yes…No

If yes, _____Packs _____Years.
Last used_____.

Do you drink alcoholic beverages? Yes…No

If yes, how many drinks per week?_____

During the past month:

Have you often been bothered by little interest or pleasure in doing things?.....Yes…..No

Have you often been bothered by feeling down, depressed or hopeless?.....Yes…..No

Are you pregnant? Yes…No

Estimated Delivery Date_____

Are your symptoms: (check one)

Worsening ____ The same ____ Improving ____

Do you consider yourself under stress?

Yes____ No_____

My symptoms are <u>WORST</u> in the:

Morning ____ Afternoon ____ Evening____
Night ____ After Activity_____ N/A_____

My symptoms are <u>BEST</u> in the:

Morning ____ Afternoon ____ Evening____
Night ____ After Activity_____ N/A_____

Describe your exercise level in the last 3 months:

Strenous_____min/day_____days/week
Moderate_____min/day_____days/week
Light_____min/day_____days/week

Please list current medications you are taking:

_____
_____
_____
_____
_____
_____
_____
_____

Please describe any other health conditions you may have (Including previous surgery):

_____
_____
_____
_____
_____
_____
_____

Name:_____ **Date:**_____/_____/_____
mm dd yy

Here are some of the things other patients have told us about their pain. For each statement please circle the number from 0 to 6 to indicate how much physical activity such as bending, lifting, walking or driving affect or would affect your pain.

	Completely Disagree			Unsure			Completely Agree
1. My pain was caused by physical activity.	0	1	2	3	4	5	6
2. Physical activity makes my pain worse.	0	1	2	3	4	5	6
3. Physical activity might harm my pain area.	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your pain.

	Completely Disagree			Unsure			Completely Agree
6. My pain was caused by my work or by an accident at work.	0	1	2	3	4	5	6
7. My work aggravated my pain.	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain.	0	1	2	3	4	5	6
9. My work is too heavy for me.	0	1	2	3	4	5	6
10. My work makes or would make my pain worse.	0	1	2	3	4	5	6
11. My work might harm my injury.	0	1	2	3	4	5	6
12. I should not do my regular work with my present pain.	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain.	0	1	2	3	4	5	6
14. I cannot do my normal work until my pain is treated.	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to that work.	0	1	2	3	4	5	6

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

SIGNATURE: _____ **DATE:** _____

DISABILITY INDEX SCORE: **%**_____