

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.



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 deductible 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**

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 WORST in the:
Morning ____ Afternoon ____ Evening ____
Night ____ After Activity ____ N/A ____

My symptoms are BEST 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

THE

QuickDASH

OUTCOME MEASURE

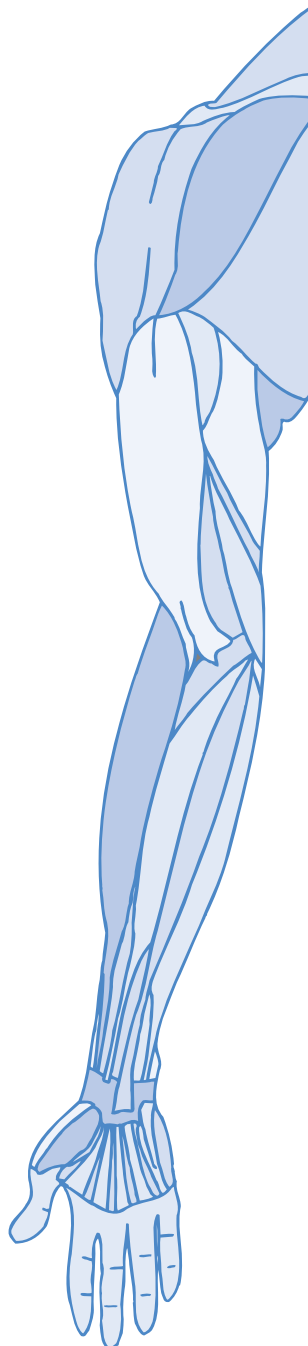
INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.



QuickDASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (*circle number*)

	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (<i>circle number</i>)	1	2	3	4	5

QuickDASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{sum of } n \text{ responses}}{n} \right] - 1 \right) \times 25$, where n is equal to the number of completed responses.

A QuickDASH score may not be calculated if there is greater than 1 missing item.

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is: _____

I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you: _____

I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.

An optional module score may not be calculated if there are any missing items.