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:____

Date of Onset (Injury, accident, surgery date or recent date symptom started): ____________________________

Refering Doctor:_____________________ Diagnosis:_____________________

How did you hear about us?

☐ MD ☐ Self ☐ Existing patient/Friend ☐ Newspaper ☐ Website ☐ Other : _____________________

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:_______ Deductible:_______ Met? Y or N RX required? Y or N Pre-Auth Required? Y or N

Coverage Details:____

Insurance Verifier Name:_______________ Date_______ Time:_____ Reference#:___________________

Secondary Insurance: ___________________________________ Phone:______________________

Policy or ID#:______________________ Coverage Details:____

Musculoskeletal Pain Diagram

Name: ____ Date: __________________ Age:_____
Gender:___ Height______ Weight______ 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" 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:

____

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

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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 we are committed to providing you with amazing service throughout your experience with us. In order to do so, we offer the following information:

<u>INSURANCE</u>

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.

<u>CO-PAYS</u>

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.

<u>COINSURANCE</u>

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.

<u>DEDUCTIBLES</u>

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.

<u>SELF-PAY PATIENTS</u>

Payment is due at time of service. KEPT does not submit a claim on your behalf to the insurance company for self-pay patients.

<u>Medicare</u>

A physician's referral is required specifying the **duration and frequency** for physical therapy. Secondary coverage **may** help to cover additional costs (please call your secondary insurance company for details).

<u>STATEMENTS</u>

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.

<u>No-Show and Cancellation Policy:</u> You, as a patient at Kinetic Energy PT, are <u>personally responsible</u> for your appointments. We reserve the right, at our discretion, to charge a <u>$80 No Show fee</u> which is not billable to your insurance company.

Consent to Physical Therapy

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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. **Cancellation Policy**: __________ initials
   - **You will be charged $80 for any appointment cancelled <u>less than 24 business hours</u> from your scheduled appointment time.** Payment is expected prior to your next scheduled appointment
5. **No-Show Policy:** __________ initials
   - **<u>$80 no show fee</u> <u>will automatically be charged to your account balance</u>** If you do not show up for an appointment and do not call. Payment is expected prior to your next scheduled appointment. Two no-show appointment may result in removal of any future appointment.

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 Unencrypted Email and Texting

Yes, I would like to receive information regarding my care, appointment reminders, administration services and billing/financial invoices from my physical therapist and/or KEPT staff utilizing **plain unencrypted email/texting**.

> ***I understand the inherent risk that plain email and texting are not secure and accept that this communication can be compromised.*
> ***carrier charges may apply to your account*

◯_____________ **initial**