Kinetic Energy PT New Patient Information

Patient Name:_____

Billing/Mailing Address (If not already provided online):_____
City:_____ State:_____ Zip:_____

Social Security #(Only required if used as identifier for insurance company):_____

Referring Physician:_____ Diagnosis:_____

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

☐ Check here if you do not want to receive KEPT's quarterly newsletter via email

Policy Holder Information (person financially responsible *if not already provided above*)

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: _____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Kinetic Energy Physical Therapy PC's LEGAL DUTY

Kinetic Energy Physical Therapy PC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USE AND DISCLOSURES OF HEALTH INFORMATION

Kinetic Energy Physical Therapy PC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Kinetic Energy Physical Therapy PC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Kinetic Energy Physical Therapy PC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Kinetic Energy Physical Therapy PC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Kinetic Energy Physical Therapy PC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Kinetic Energy Physical Therapy PC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Kinetic Energy Physical Therapy PC may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Kinetic Energy Physical Therapy PC's health information practices or if you have a complaint, please contact the following person:

Kinetic Energy Physical Therapy PC
Nicole P Rabanal PT, CSCS
PO Box 883299, Steamboat Springs, CO 80488
Telephone: 970-879-8026 or Fax: 970-879-8046

I have read and fully understand Kinetic Energy Physical Therapy PC's Notice of Information Practices. I understand that Kinetic Energy Physical Therapy PC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to designate individuals to whom my information can be released. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations of I notify the practice. I also understand that Kinetic Energy Physical Therapy PC will consider requests for restriction on a case my case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Kinetic Energy Physical Therapy PC's Notice of Information practices. I understand that I retain the right ot revoke this consent by notifying the practice in writing at any time.

_____ Initials

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 (similar to accupuncture) Joint manipulation/"popping" Massage
   Electrical Stimulation 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:

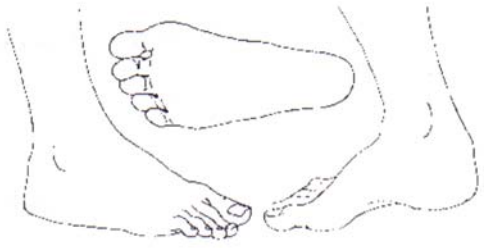
0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

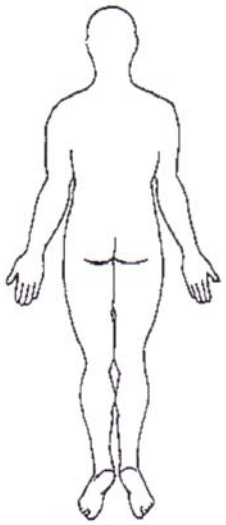
Please rate your pain at it's worst:

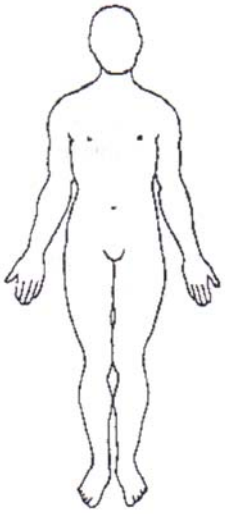
0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

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
Lung 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/fainting	Yes…No
Infection	Yes…No
Change in your balance	Yes…No
Pain at night	Yes…No
Excessive Fatigue/shortness of breath	Yes…No
Incontinence	Yes…No
Rashes or skin irregularity	Yes…No
Headache	Yes…No
Difficulty with hearing/vision/speech	Yes…No
Use of steroid medications	Yes…No
Swelling of ankles	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):

_____

_____

_____

_____

_____

_____

_____

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity
 I can tolerate the pain I have without having to use pain medication.
 The pain is bad, but I can manage without having to take pain medication.
 Pain medication provides me with complete relief from pain.
 Pain medication provides me with moderate relief from pain.
 Pain medication provides me with little relief from pain.
 Pain medication has no effect on my pain.

Personal Care (e.g., Washing, Dressing)
 I can take care of myself normally without causing increased pain.
 I can take care of myself normally, but it increases my pain.
 It is painful to take care of myself, and I am slow and careful.
 I need help, but I am able to manage most of my personal care.
 I need help every day in most aspects of my care.
 I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting
 I can lift heavy weights without increased pain.
 I can lift heavy weights, but it causes increased pain.
 Pain prevents me from lifting heavy weights off the floor, but I can manage
if the weights are conveniently positioned (e.g., on a table).
 Pain prevents me from lifting heavy weights, but I can manage
light to medium weights if they are conveniently positioned.
 I can lift only very light weights.
 I cannot lift or carry anything at all.

Walking
 Pain does not prevent me from walking any distance.
 Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
 Pain prevents me from walking more than 1/2 mile.
 Pain prevents me from walking more than 1/4 mile.
 I can walk only with crutches or a cane.
 I am in bed most of the time and have to crawl to the toilet.

Sitting
 I can sit in any chair as long as I like.
 I can only sit in my favorite chair as long as I like.
 Pain prevents me from sitting for more than 1 hour.
 Pain prevents me from sitting for more than 1/2 hour.
 Pain prevents me from sitting for more than 10 minutes.
 Pain prevents me from sitting at all.

Standing
 I can stand as long as I want without increased pain.
 I can stand as long as I want, but it increases my pain.
 Pain prevents me from standing for more than 1 hour.
 Pain prevents me from standing for more than 1/2 hour.
 Pain prevents me from standing for more than 10 minutes.
 Pain prevents me from standing at all.

Sleeping
 Pain does not prevent me from sleeping well.
 I can sleep well only by using pain medication.
 Even when I take medication, I sleep less than 6 hours.
 Even when I take medication, I sleep less than 4 hours.
 Even when I take medication, I sleep less than 2 hours.
 Pain prevents me from sleeping at all.

Social Life
 My social life is normal and does not increase my pain.
 My social life is normal, but it increases my level of pain.
 Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
 Pain prevents me form going out very often.
 Pain has restricted my social life to my home.
 I have hardly any social life because of my pain.

Traveling
 I can travel anywhere without increased pain.
 I can travel anywhere, but it increases my pain.
 My pain restricts my travel over 2 hours.
 My pain restricts my travel over 1 hour.
 My pain restricts my travel to short necessary journeys under 1/2 hour.
 My pain prevents all travel except for visits to the physician / therapist or hospital.

Employment / Homemaking
 My normal homemaking / job activities do not cause pain.
 My normal homemaking / job activities increase my pain, but I can still perform all that is
required of me.
 I can perform most of my homemaking / job duties, but pain prevents me from
performing more physically stressful activities (e.g., lifting, vacuuming).
 Pain prevents me from doing anything but light duties.
 Pain prevents me from doing even light duties.
 Pain prevents me from performing any job or homemaking chores.

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

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

We are delighted to extend a 25% cash courtesy discount to patients electing to self-pay at the time of service. Special payment arrangements can be made as needed at your initial visit if there is a financial hardship situation.

Medicare

A physician's referral is required specifying the **duration and frequency** for physical therapy **every 90 days**. Maximum coverage is a combined benefit of $1870.00/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 $40 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 my 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 this authorization. **I have read and fully understand the patient financial responsibilities form.**

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____

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

_____

Witness (authorized signature of Kinetic Energy PT employee) Date

Intramuscular Manual Therapy aka Trigger Point Dry Needling (TDN) Consent

During your time with us we may recommend a specialized form of treatment referred to as trigger point dry needling (TDN), and *the State of Colorado requires us to obtain specific consent to perform this treatment.* TDN involves placing a small needle into a tight or tender muscle with the intent of causing the muscle to contract and then release, which helps to improve the flexibility of the muscle and decrease pain. This treatment does not stimulate distal or auricular points, as is done in acupuncture.

While serious complications from TDN are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment. The risks of TDN include:

COMMON (1-10%): muscle soreness, bruising, minor bleeding
RARE (.1-1%): fainting, headache
SERIOUS (.05 per 10,000 treatments): Pneumothorax

Nicole Rabanal, PT, CSCS has completed 93 hours of training in this procedure fully meeting the requirements of the State of Colorado to perform TDN. Finn Gerstell, DPT has completed a Level 1 course and according to the State of Colorado is allowed to perform TDN clinically in order to complete his course of study.

_____(initial) I consent to the use of TDN treatment if recommended by my attending physical therapist (we will thoroughly review the benefits, risks, and benefits prior to any treatment).