PATIENT DEMOGRAPHICS

Name* ______ Date of Birth* ______ Age ______

Parents or Guardian(if minor) ______

Home Number ______

Cell Number ______

Work Number ______

Address* ______

City* ______ State* ______

Zip* ______

Email* ______

EMERGENCY CONTACT

Name* ______ Phone Number* ______

Relationship* ______

PRIMARY INSURANCE

Name of Insurance Carrier* ______ Group number* ______

Policy Number* ______

If Patient and Policy Holder are the same please check ☐

Policy Holder Name ______ Date of Birth ______

SECONDARY INSURANCE (IF APPLICABLE)

Check if primary insurance is the same as secondary insurance ☐

Name of Insurance Carrier ______ Group number ______

Policy Number ______

If Patient and Policy Holder are the same please check ☐

Policy Holder Name ______ Date of Birth ______

AUTO INSURANCE (IF APPLICABLE)

Adjuster's Name ______ Date of Injury ______

Insurance Carrier's Name ______ Adjuster's Phone Number ______

Do you have a MD prescription ○ Yes ○ No Referring MD ______

How did you hear about us? ______

HISTORY OF PRESENT CONDITIONS

Please describe what brings you in to Physical Therapy ______

How and when did your current issue/ injury start? ______

Did you have surgery ○ Yes ○ No If Yes, Date ______

Type of Surgery ______

What specific physical activity are you having the most difficulty completing because of your current condition?* ______

On a scale of 0-10, how difficult is that activity today? (0=unable, 10= no difficulty) *

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

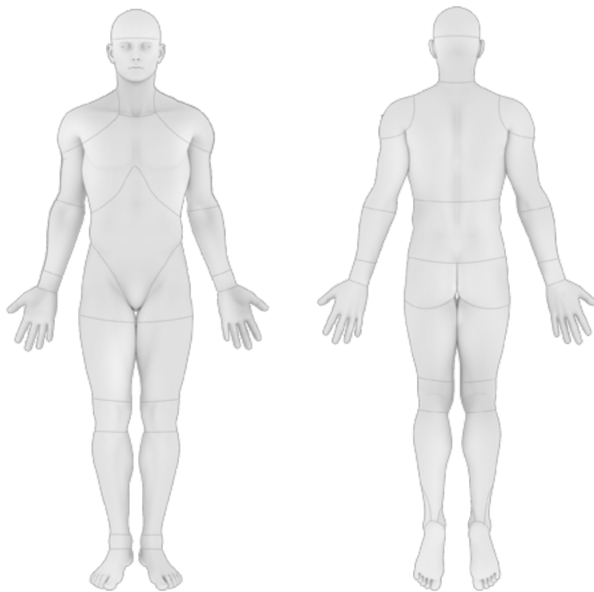
How would you rate your current condition as a percentage of your normal function? (0%= bed bound, 100% = Normal) * ____________

Have your received treatment for this before? ○ Yes ○ No

Did it get better? ○ Yes ○ No

Where? ____________ When? ____________

PAIN DRAWING



PAIN RATING

- please rate your pain in the scale below, circle the number that best represents your pain:

Feel Great | Annoying | Nagging Pain | Hurts even more | Intense Horrible | Unbearable

Worst pain in the past 48 hours: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Current intensity of pain:* ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Best pain in the past 48 hours: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What makes your pain worse? ____________

What makes your pain better? ____________

When is your pain the worst? ○ Morning ○ Night ○ At Rest ○ During Activity ○ After Activity

Are your symptoms: ○ Constant ○ Intermittent ○ Improving ○ Worsening ○ Unchanging ○ Activity Dependent

Do your symptoms interrupt your sleep? ○ Yes ○ No

Does coughing, sneezing or taking a deep breath change your symptoms? ○ Yes ○ No

PATIENT MEDICAL SCREENING QUESTIONNAIRE

Do you smoke? ○ Yes ○ No

Do you have a pacemaker? ○ Yes ○ No

Do you use a ○ Cane ○ Walker ○ Wheelchair ○ Other ____________

Women only: Are you currently pregnant or think you may be pregnant: ○ Yes ○ No

Past Medical History: Please check all that apply, if none apply check here ☐

☐ Alzheimer s	☐ Diabetes Type 2	☐ Immunosuppression	☐ Rheumatoid Arthritis
☐ Cardiovascular Disease	☐ Fibromylagia	☐ Lupus	☐ Traumatic Brain Injury
☐ Cauda Equina Syndrome	☐ Fracture or Suspected Fracture	☐ Muscular Dystrophy	☐ Asthma
☐ Cerebral Vascular Accident	☐ High Blood Pressure	☐ Obesity	
☐ Current Infection	☐ History of Cancer	☐ Osteoarthritis	
☐ Diabetes Type I	☐ Huntington s	☐ Parkinson s	

☐ Other ____________

Has anyone in your family ever been diagnosed with any of the above? If so, please list below:

Please list any surgeries or other conditions, with dates, for which you have been hospitalized:

Please list any previous injuries and date:

Please list any diagnostic tests (x-rays, MRI, EMG, CT etc.) and dates performed:

Have you RECENTLY noted any of the following Please check all that apply, if none apply check ☐

☐ Fatigue	☐ Sudden Weight Loss/Gain	☐ Shortness of Breath	☐ Fever/Chills
☐ Headaches	☐ Difficulty Walking	☐ Loss of Balance	☐ Nausea/Vomiting
☐ Falls	☐ Difficulty Swallowing	☐ Numbness/Tingling	☐ Constipation/Diarrhea
☐ Dizziness	☐ Lightheadedness	☐ Muscle Weakness	☐ Heartburn/Indigestion
☐ Changes in Bladder/Bowel Function		☐ Depression	

If you are currently not taking any medications please check here: ☐

Please list current medications, over the counter medication, vitamins, and supplements (include dosage and purpose):

What are your goals or things you want to get back to doing?

AUTHORIZATION TO TREAT

I voluntarily consent to Physical Therapy consisting of evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatments being provided. I authorize KINĒCIO to provide such treatments. My healthcare provider, Insurer, or plan may require a Physician referral or prior authorization. I may be obligated for partial or full payment for therapy services rendered.

PAYMENT AUTHORIZATION

I understand that all balances designated as the patient s responsibility such as co-insurance, co-payments and deductibles are due and payable to KINĒCIO. As part of working with my insurance carrier, I understand and acknowledge that I am financially responsible for services received from KINĒCIO and personally guarantee payment in the event that services are not paid for by my insurance company. Further, I guarantee payment with my credit card and authorize KINĒCIO to charge my credit card for any unpaid account balance that remains 60 days after charge has been incurred, including co-pays, deductibles, and a service charge of $50 for each un-kept appointment.

INSURANCE BENEFITS ASSIGNMENT

I authorized that the payment of my insurance benefits be made directly to KINĒCIO for all services delivered; if I am paid directly I will promptly pay KINĒCIO all monies paid to me.

HIPPA PRIVACY POLICY

By signing below I indicate that I have been given the Notice of Privacy Practices for KINĒCIO Physical Therapy. I understand that outside of purposes of treatment, for payment, for certain healthcare operations or as permitted or by law I must give my written authorization to KINĒCIO to release any of my protected healthcare information.

CANCEL/NO SHOW POLICY

We ask that if you are unable to keep your appointment, that a 24-hour notice is given. We understand emergency situations may arise and just ask that you call us as soon as possible. We will apply a service charge of $50 for each un-kept appointment. Following 2 consecutive No Shows, all future appointments will need to be prepaid by credit card, check or cash at the time of scheduling.

RECORD RELEASE

I am aware that KINĒCIO may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, ORC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care.

REMINDER EMAIL/TEXTS

As a service to our clients, we provide reminder emails and texts regarding your appointments. By providing your phone number and email you consent to these correspondences.

GOOD FAITH ESTIMATE OF TIME-OF-SERVICE FEES

All visits of therapy paid for at time of service, also known as Prompt Pay, will be billed at $125 for a 40-minute session, or $180 for a 60-minute session. These estimates do not include the cost of supplies or equipment, which may be recommended by your therapist, but cannot be determined until the care commences.

This Good Faith Estimate shows the costs of services that are reasonably expected for your health care needs. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if special circumstances occur. If this happens, and your bill is $400 or more from any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

You may contact KINECIO to let us know the billed charges are higher than the Good Faith Estimate. You can ask for an updated bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, KINECIO cannot move the bill for the disputed item or service to collections or threaten to do so, or if the bill has already moved into collections, KINECIO has to cease collection efforts. KINECIO must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. KINECIO cannot take or threaten to take any retributive action against you for disputing your bill. There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price of the Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

☐ I HAVE READ AND UNDERSTOOD AND AGREE TO UPHOLD THE POLICIES OF KINĒCIO PHYSICAL THERAPY

Medicare patients only: Are you currently or in the last 30 days received Home Health Care? ○ Yes ○ No

If yes, you must provide discharge papers at first appointment

Patient's Initials* (parent/guardian if minor)		Guardian Relationship*	
Full Name*		Date	