Kenetic Physical Therapy Intake Form

Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Insurance: _____
Who referred you? _____

History of present illness

Tell me what happened: _____

_____

_____

What medications are you currently using? _____

Past Surgical history: _____
Height and Weight: _____

Complaint

Start Date _____ Possible Cause: _____
Symptoms: _____
Previous doctors seen for complaint: _____
Any history of falls? _____
Symptom-Aggravating Factors: _____
Symptom-Relieving Factors: _____

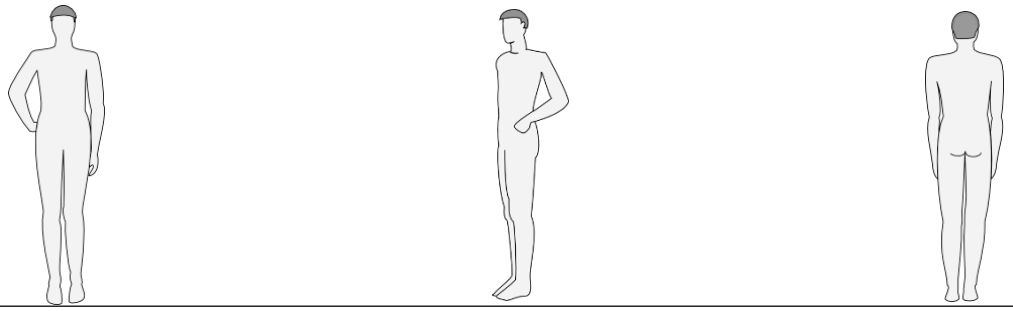
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

Is your pain getting better or worse?_____

Do You Have Any of the Following Today? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Areas of Discomfort



_____ _____
Signature Date

Consent and Statement of Financial Responsibility

1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Kenetic Physical Therapy PC , I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Kenetic Physical Therapy PC with current insurance information and to familiarize myself with my insurance plan and its policies. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance. When you provide a check as payment in the clinic, you authorize us to use the information from your check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day and you will not receive your check back from your financial institution.

3. ASSIGNMENT OF BENEFITS: I hereby assign to Kenetic Physical Therapy PC all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

4. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Kenetic Physical Therapy PC may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Kenetic Physical Therapy PC administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Kenetic Physical Therapy PC Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

5. HIPAA CONSENTS: In compliance with HIPAA regulations, I authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and provided the information to the best of my knowledge. Please sign below:

_____ _____

Signature of Patient or Legally Responsible Person Date Signed:

_____

Printed Name of Above

Kenetic Physical Therapy PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.