

\*\*\*CO-PAYS TO BE COLLECTED AT TIME OF VISIT\*\*\*

**NEW PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Street: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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How do you prefer we contact you? Home Phone: \_\_\_ Cell Phone: \_\_\_ E-mail: \_\_\_\_\_  
Do we have your permission to leave voicemails regarding appointments? **Yes** **No**  
How did you hear about us? \_\_\_\_\_

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Employer: \_\_\_\_\_  
Street: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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Referring Physician: \_\_\_\_\_ Hospital/Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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In case of emergency, please contact: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Have you had physical therapy anywhere in the past 12 months? YES NO**

\*\*\*\*\*PLEASE PRESENT YOUR INSURANCE CARD FOR PHOTOCOPYING\*\*\*\*\*

**IF YOU ARE NOT THE PRIMARY SUBSCRIBER OF YOUR HEALTH INSURANCE,  
PLEASE FILL IN THE FOLLOWING:**

**Name of Subscriber:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Relationship to Subscriber:** \_\_\_\_\_ **Subscriber Employer:** \_\_\_\_\_

Was this injury employment related? \_\_\_\_\_

Was this injury due to a motor vehicle accident? \_\_\_\_\_

**Please provide billing information if claim is being processed through worker's  
compensation or motor vehicle insurance.**

Work/Auto insurance Carrier: \_\_\_\_\_ Date of injury/loss: \_\_\_\_\_  
Adjuster Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claim #: \_\_\_\_\_ Insurance Co. Billing address: \_\_\_\_\_

**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Next MD Appointment: \_\_\_\_\_

*Please fill out as accurately as possible. Space is provided below for explanations if necessary. Your answers are designed to provide the therapists with the necessary information to ensure your safety and treatment effectiveness.*

**DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING:**

	<b>YES</b>	<b>NO</b>
High or low blood pressure		
High cholesterol		
Heart problems or cardiac irregularities		
Family history of cardiac problems		
Pacemaker or metal implants		
Cancer (indicate type)		
Family history of cancer		
Recent unexplained weight loss		
Diabetes (Type 1 or 2)		
Systemic disorders (i.e. RA, MS, AIDS, etc)		
Allergies including latex or medication		
Respiratory ailments, including asthma		
Intestinal organ problems (stomach, kidneys, etc)		
Osteoporosis		
Alcohol or drug addiction		
Neck strain		
Low back pain		
Fractures		
Arthritis (indicate joint)		
Ligament sprain, muscle strain		
Do you smoke? If so, how much?		
Concussion? If so, how many?		

Please explain the YES answers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_

Have you had any significant falls in the past year? \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

Please list any medications you are taking, including dosages and frequency:

\_\_\_\_\_

\_\_\_\_\_

Please list any other significant ailments or problems that have required medical treatment in the past:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any ailment for which you are currently undergoing treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any surgeries, including dates:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you under any specific instructions or precautions from a physician?

\_\_\_\_\_

\_\_\_\_\_

Do you have any precautions concerning exercise or physical activity?

\_\_\_\_\_

\_\_\_\_\_

Female patients: Is there any chance you could be pregnant? \_\_\_\_\_

*Sign below to indicate you have answered all questions accurately and to the best of your ability.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT CONSENT FORM / NOTICE OF PRIVACY PRACTICES  
ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at their address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

*I have read and understood the above. (If under 18, a parent or guardian must sign below.)*

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date: \_\_\_\_\_

**Office Use Only**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

NAME	DATE	REASON
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## **Patient's Rights and Responsibilities**

### **Patient's Rights:**

1. To be provided with courteous, considerate care, as well as be treated with respect.
2. To privacy and confidentiality with regard to treatment and medical records.
3. To review your medical records in the company of a professional. All records will remain the property of Kennedy Brothers PT, however, a request for records may be made in writing.
4. To be informed of the effectiveness of treatment, and to know the possible risks or alternative methods of treatment.
5. To have a choice of clinician and to change clinicians if desired.
6. To know who is treating you, and their role in the clinic.
7. To refuse treatment, or to ask for a second opinion or alternative course of treatment, and to be informed of the medical consequences of your actions.
8. To be informed of your personal responsibilities involved in your treatment and maintaining your health and well-being after treatment.
9. To bring any dissatisfaction to the attention of your health care provider.
10. Accept personal financial responsibility for all charges that are not covered by insurance companies.

### **Patient's Responsibilities:**

1. To present accurate identifying information. This includes information about all aspects of his/her health condition, past medical history, medications, including over the counter products and dietary supplements, and any other allergies or sensitivities.
2. To present details of injury or complaint in a straight forward manner.
3. To cooperate responsibly with all persons involved in the health care process.
4. To keep appointments on time.
5. To cancel appointments only when absolutely necessary, and with 24 hours notice to that other patients may utilize that time.
6. To pay for all services rendered according for any charges not paid for by health insurance.
7. To comply with the treatment plan provided by the health professional.
8. To ask for clarification whenever information or instructions are not understood.
9. To provide both positive and negative feedback to health professional responsible for care.
10. Be respectful of all health care professionals and staff, as well as other patients.

**PLEASE SIGN AND RETURN**

- I understand that I am responsible for obtaining all referrals and prescriptions needed for insurance coverage.
- I understand that I am responsible for understanding the benefits available to me under my personal insurance plans, including deductibles or co-pays.
- I will be personally responsible for all deductible or co-pay expenses.
- I will assume financial responsibility for any charges not covered by insurance.
- Medicare patients will be responsible for getting a new MD prescription every 30 days.
- I understand that Kennedy Brothers Physical Therapy will not bill my attorney directly. I understand my claims will be submitted directly to the insurance carrier and I will provide the office with the appropriate information. Kennedy Brothers will forward copies of billing information to my attorney with my written receipt.
- I will make every effort to cancel my appointments within 24 hours notice. I understand that cancellations and no-shows may affect others that are in need of appointments. I understand that if I am consistently not showing up for appointments at their scheduled time or canceling appointments with less than 24 hours notice, I may be charged a \$25 cancellation fee.
- Co-payments will be due at the time of your visit.

*I have read and understood the above. (If under 18, a parent or guardian must sign below.)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_

**I have read and understand the Patient’s Rights and Responsibilities.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_