****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: _____

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**
Do you consent to email statements? **Yes** **No**

Employer: _____
Street: _____ Business Phone: _____
City: _____ State: _____ Zip Code: _____

Referring Physician: _____ Hospital/Facility:_____
Address: _____
Phone: _____ Fax: _____

Primary Care Physician: _____
Address: _____
Phone: _____ Fax: _____

In case of emergency, please contact: _____
Phone number: _____Relationship: _____

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:_____

Patient Name: _____ Date: ____ / ____ / _____

MEDICAL HISTORY

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 <u>ever</u> had any of the following:

Condition	Yes	No
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? _____

Patient Name: _____ Date: ____ / ____ / _____

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 Name: _____ 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**

Patient Name: _____ Date: ____ / ____ / _____

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 healthcare 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 straightforward 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 might 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:_____