Kinetic Physical Therapy & Wellness

Therapy Registration Form

Please fax to: (252) 364-2863 or mail to: 1540 East Arlington Blvd., Greenville, NC 27858
Phone: (252) 364-2806 email: info@kineticptgreenville.com

___ PHYSICAL THERAPY ___ OCCUPATIONAL THERAPY ___ SPEECH THERAPY

PATIENT INFORMATION

Name (Last, First, Middle Initial)**

Address (if P.O. Box, also enter physical address)**

City, State, Zip code**

Telephone
(Please enter cell number and provider if you want appointment reminders to come to your phone)

Birthdate** Sex (circle) M F Marital Status (circle) S M O

SS number of patient

Email Address**:
(We use this for appointment reminders)

MEDICAL INFORMATION

Physician Name

Address

City, State, Zip code

Telephone

Diagnoses/Problems/Reason for Attending:

How long has this problem been present?

What are your personal goals for attending therapy?

Please list any allergies:

EMERGENCY CONTACT NAME AND PHONE NUMBER

Name Phone:

Relationship

BILLING / PAYMENT INFORMATION

Name of Insured (from ID Card) | SS number of Insured

Relationship to Patient (circle)
Self Spouse Parent Other (Specify)

Address (if P.O. Box, also enter physical address)

City, State, Zip code

Telephone:

COMPLETE INSURANCE INFO IF YOU DO NOT HAVE YOUR CARD WITH YOU.

☐ Medicare B Traditional:

☐ Other Private Insurance Name / Phone Number on ID Card

ID Number on card

Group Number

☐ Wokers Comp Agency

☐ Veterans Administration

☐ Medicaid Number: | Eligible | Carolina Access
Access number: | Y N | Y N

Therapy History

Have you had any therapy services anywhere else this year?
Y N How Long? _____
(circle one)

What was done?

What were the results?

Are therapy services currently being received elsewhere? Where? (circle one)
Y N Hospital Outpatient Home Health Rehab Center

(OFFICE USE)
PHYSICIAN'S ORDERS: _____
Staff Taking Order: _____ Medical Records Received Date: _____

Appointment With: _____ **Appt Date** _____

Kinetic Physical Therapy & Wellness

1540 East Arlington Blvd. Greenville, NC 27858

Admission Agreement & Consent for Treatment

Patient's Name _____ Birthdate _____

PERMISSION FOR TREATMENT:

I hereby authorize the staff of Kinetic Physical Therapy and Wellness, Inc. to administer therapy services as ordered by my physician (physician's order is not necessary for self-pay patients) and as are included in my plan of treatment I consent for referral to a hospital or physician for the purpose of provision of emergency medical care if indicated even if I am unable to provide permission at the time of the emergency.

PERMISSION TO RELEASE INFORMATION:

I hereby authorize any holder of medical or other information about me to release all medical records, financial records, and other information needed by Kinetic Physical Therapy and Wellness, Inc. to provide services or to secure payment for services to Kinetic Physical Therapy and Wellness, Inc. I also authorize Kinetic Physical Therapy and Wellness, Inc. to release any and all medical records, financial records, and information to any of my payment sources, including my attorney if applicable, or to the referring agency, physician, or caseworker. I agree that this authorization is irrevocable and is in effect until services are paid in full. Release of information to entities other than those identified above, such as other providers, requires the completion of a *Consent for the Release of Information Form* which identifies the intended recipient of specified information. Information will not be released without appropriate signed consent unless required by State or Federal laws. A *Consent for the Release of Information Form* is valid for the duration of the admission, or until revoked by the patient or responsible party, or until the expiration of one year. I give unrestricted permission for my information to be released to the referring physician or provider or case manager.

AUTHORIZATION FOR PAYMENT:

I hereby certify that the information given by me in applying for payment from my insurance is correct. I acknowledge that no employee of Kinetic Physical Therapy and Wellness, Inc. can guarantee payment by any of my payment sources and that I will be responsible for obtaining any authorizations required by my payment sources. I assign to Kinetic Physical Therapy and Wellness, Inc. all rights, title and interest in and to any party liability arising out of injuries sustained by me necessitating the services provided, up to the amount necessary to discharge the debt due to Kinetic Physical Therapy and Wellness, Inc. I request that payment be made directly to Kinetic Physical Therapy and Wellness, Inc. I am aware that Kinetic Physical Therapy and Wellness, Inc. will file my insurance as a courtesy, but I have the ultimate responsibility for payment. I will be responsible for services rendered that are not paid by the aforementioned payment sources. Returned checks will incur a $35 fee. I agree that this authorization is irrevocable and that if my account is not paid in 60 days, I agree to pay all costs of collection, including reasonable attorney's fees If any part of this document is unenforceable, I intend that all other provisions remain enforceable.

I have read and fully understand this information. I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms. I have received information regarding patient rights and responsibilities, Inc. I have received the Notice of Privacy Practices. If I have questions or concerns about HIPAA or Privacy Practices, I can contact the privacy officer at (252) 364-2806.

Name of responsible party (please print) _____ SS# _____

Signature _____ Date _____ Witness _____

Mailing address _____ Street address _____

City _____ State _____ Zip _____ Phone _____

Kinetic Physical Therapy and Wellness, Inc.
PATIENT HISTORY FORM – CONFIDENTIAL

Name: _____ Date:_____

Past Medical History (Check all that currently or previously apply to you personally):

System Review:

- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Diabetes – Type I/Type II (circle)
- ❑ Headaches (specify) _____
- ❑ Cancer (specify) _____
- ❑ Stroke/TIA
- ❑ Asthma
- ❑ Pacemaker/Arterial Stent(s)
- ❑ Skin Cancer or Lesions
- ❑ Lymphoma
- ❑ Leukemia
- ❑ Prostatitis/Elevated PSA
- ❑ Endometriosis
- ❑ Sleep Apnea
- ❑ Anxiety/Depression (circle)
- ❑ Allergies (specify)_____
- ❑ Stomach Ulcers
- ❑ Lung Disease/COPD
- ❑ Liver Disease (specify)_____
- ❑ Kidney Disease (specify)____
- ❑ Hyperthyroid
- ❑ Hypothyroid

❑ Autoimmune/Inherited Condition (e.g., Blood disorders, Polio, Chron's Disease, IBS, Paget's Disease)
If yes, please list: _____

List All Family History:_____

Musculoskeletal Review:

- ❑ Gout
- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Scoliosis
- ❑ Psoriasis/Psoriatic Arthritis
- ❑ Disc Degeneration
- ❑ Bone Spurs
- ❑ Rheumatoid Arthritis
- ❑ Ankylosing Spondylitis
- ❑ Lupus
- ❑ Fibromyalgia
- ❑ Reiter's Syndrome
- ❑ Reynaud's
- ❑ TMJ/Bruxism (Jaw Clenching)
- ❑ Double Vision
- ❑ Weakness
- ❑ Neuropathy
- ❑ Peripheral Circulatory Problems
- ❑ Swelling of hands or feet (specify)
- ❑ Coldness of hands or feet (specify)
- ❑ Foot Drop/Weakness
- ❑ Dizzines/Vertigo
- ❑ Facial Numbness/Pain
- ❑ Multiple Sclerosis
- ❑ Other: _____

❑ Medical/Artificial Implants/Previous Bone Fractures
If yes, please list: _____
❑ Recent steroid injections/current corticosteroid prescription

Please list all current medications (prescribed, over the counter, herbs/vitamins) you are taking:

Medication Name	Strength (i.e., 50mg)	Frequency Taken	Prescribed By

Please indicate if you use the following substances:

Tobacco	_____Never	_____Rarely	_____Daily	_____(amount)
Alcohol	_____Never	_____Rarely	_____Daily	_____(amount)
Recreational Drugs	_____Never	_____Rarely	_____Daily	_____(amount)
Caffeine/Carbonated Soda	_____Never	_____Rarely	_____Daily	_____(amount)

Patient Name:_____ **DOB:**_____

The therapist may ask you to rate your pain on a scale from 0 to 10 with 0 being no pain and 10 being the worst pain imaginable that you have ever felt.

Please mark all areas of pain or symptoms as follows:

Sharp Pain	*
Dull Pain	+
Numbness	N
Tingling	T
Spasm	S