



PHYSICAL THERAPY, P.A.

PLEASE PRINT CLEARLY

Name: _____ Today's Date: _____

Current Address: _____

Other Address: _____

Day Phone: _____ Cell Phone: _____ Email address: _____

Soc. Sec. #: _____ Date of Birth: _____ Gender: Male Female

Referring Physician: _____

In Case of an emergency, Notify: _____ Phone #: _____

Who may we thank for referring you to us? _____

Is the illness/injury for which you are being seen the result of any of the following?

- Auto Accident
- Work Injury
- Other Illness/injury being litigated
- None of these

Primary Health Insurance Company: _____

Secondary Health Insurance Company: _____

Driver's License # / Photo ID: _____

Authorization to Release Information and Cancellation/No Show Policy (please initial)

____ I authorize phone messages and/or emails regarding my appointments to be left with persons or machines at the phone numbers I have provided.

____ I authorize photos and/or videos of my home exercise program to be taken and emailed to me at the address provided above or sent via text message to the phone number I provide.

____ I hereby understand that when **less than 24 hours' notice** is given, or later than Friday for a Monday appointment, I will be charged a **\$100 cancellation/no show fee**. If you are unable to keep your appointment, we expect you to call and cancel or reschedule that appointment. You are expected to arrive for your appointment on time. If you arrive more than 10 minutes late, Kriz Physical Therapy, P.A. reserves the right to reschedule your appointment. If you cancel and/or no show for 3 or more appointments, you may be required to be seen by your referring physician before continuing physical therapy. Your insurance company may deny payment for services rendered if you do not follow the plan of care established by your physical therapist and physician.

Patient's Signature: _____ Date: _____

Signature of Responsible Party: _____ Relationship: _____ Date: _____



PHYSICAL THERAPY, P.A.

Patient History Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information. If you do not understand a question leave it blank and your therapist will assist you. Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information

PLEASE PRINT CLEARLY

Name: _____

I am currently: Employed Employed with restrictions On Medical Leave Not Employed

Employer: _____

Is there anyone who can assist you with doing home exercises or activities if needed? Yes No

Next Scheduled Dr. Appointment(s): Date: _____ Physician: _____

Date: _____ Physician: _____

ALLERGIES: Please list any medication(s) or materials you are allergic to: _____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

General Health

1. Medical conditions you have or have had. (e.g. high blood pressure, diabetes, etc.)

Please list: _____

2. Have you ever been diagnosed with any of the following conditions?:

- | | | | |
|----------------------|----------------------------------------------------------|------------------------------------|----------------------------------------------------------|
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please describe what kind: | |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema/Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Arthritic Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |

3. Have you had any surgical or invasive procedures? Yes No If yes, please list: _____

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PHYSICAL THERAPY, P.A.

Patient History Questionnaire *continued*

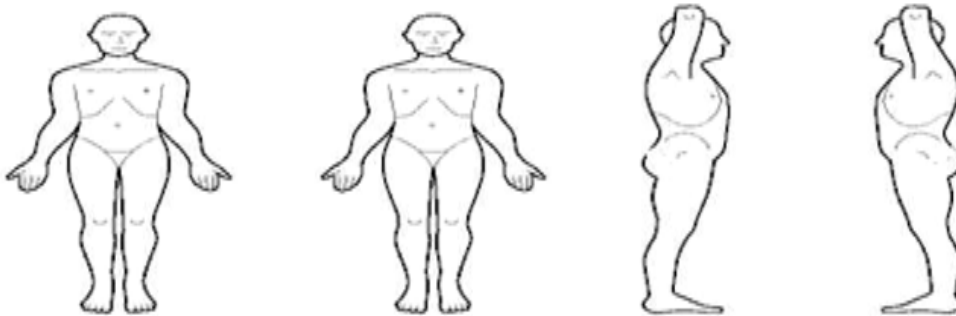
- 4. Uncontrolled leakage of urine? Yes No
- 5. Loss of bowel control? Yes No
- 6. Do you smoke? Yes No Packs per day: _____
- 7. Do you drink alcohol? Yes No Drinks per Week: _____
- 8. Is there any chance you might be pregnant? Yes No
- 9. Are you on a special diet? Yes No
- 10. How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
- 11. Which of the following over the counter medications have you taken in the past week?
 - Aspirin Tylenol Advil/Motrin/Ibuprofen Aleve Decongestants
 - Antihistamines Antacid Vitamins/Mineral Supplements Herbals/Remedies

Other (please list): _____

- 12. Are you taking any prescription medications? Yes No
If yes, please list or attach separate sheet (including pills, injections, and skin patches)

- 13. For patients 12 years and younger, is immunization/vaccination status current? Yes No
- 14. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?
 - Diabetes Cancer Heart disease Alcoholism Stroke Kidney disease
 - Depression Inflammatory Arthritis (Rheumatoid, Ankylosing)

15. Please place an X on the areas of pain:



- 16. What do you WANT TO achieve from having therapy? Check all that apply.
 - Improve home activities Improve mobility/walking activities decrease or eliminate pain/discomfort
 - Improve leisure/sports activities Return to work: Current Job Other Job
 - Improve self care activities Other: _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____



PHYSICAL THERAPY, P.A.

Acknowledgment of Receipt of Notice of Privacy Practices

As part of my health care, Kriz Physical Therapy, PA (Kriz Physical Therapy, P.A.) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among Kriz Physical Therapy, P.A.'s personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for Kriz Physical Therapy, P.A. that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that Kriz Physical Therapy, P.A. may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Kriz Physical Therapy, P.A. is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I DO NOT authorize my information shared with the following individuals or organizations (enter names below and initial the box):

I DO authorize my information shared with the following individuals or organizations (enter names below and initial the box):

I acknowledge that I have received a copy of the Notice of Privacy Practices of Kriz Physical Therapy, P.A. and agree to the liability limitations explained therein.

Signature of patient or legal representative

Date

Relationship to Patient

Printed name of patient

Effective date April 14, 2003



PHYSICAL THERAPY, P.A.

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent to **Kriz Physical Therapy, P.A.** to provide medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

Signature of Patient/Guardian/Responsible Party

Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION:

I, authorize **Kriz Physical Therapy, P.A.** to release to my insurance company any medical information necessary to process claims and treatment that I received under their care in order to secure payment. I authorize payment of any insurance benefits for physical therapy service to be paid directly to **Kriz Physical Therapy, P.A.**

Signature of Patient/Guardian/Responsible Party

Date

FINANCIAL POLICY/NOTIFICATION OF PATIENT RESPONSIBILITY:

Kriz Physical Therapy will bill your insurance carrier solely as a courtesy to you. If any payment is made directly to you for services billed, you recognize an obligation to promptly submit same to **Kriz Physical Therapy, P.A.**

It is our policy to collect your co-payments, co-insurances, and/or any unmet deductible amounts from you at the time of service. In the event that a check is returned for Non-Sufficient Funds, a \$25.00 service fee will be charged to you.

We have verified your Physical Therapy benefits with your insurance company, based on the information provided by you. Please be advised that your insurance company has the disclaimer that this is a verification of benefits only, and not a guarantee of payment. Benefits/payments are determined once the claim is received. We do not accept responsibility for the accuracy of the information provided by your insurance company. We recommend that you contact your insurance company directly if you have any questions or concerns regarding your benefits.

The following is an **estimate** of the amount(s) you are responsible for and your benefits provided to us by your insurance company:

Co-Payment \$ _____ /visit or Co-Percentage _____ %/visit

Deductible Amount \$ _____ Deductible Amount Met \$ _____ Max Out of Pocket \$ _____

Other Benefit Information: _____

Please Note: Coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balances. Any remaining balance due will be billed to you after additional information is received from your insurance company.

Please verify that you understand your financial responsibility by signing and dating this form:

I understand and agree that if I fail to make any payments I am responsible for in a timely manner, I will be responsible for all costs of monies owed, including court cost, collection agency fees, and attorney fees.

Signature of Patient/Guardian/Responsible Party

Date

Clinic Representative

Date



PHYSICAL THERAPY, P.A.

Concierge Practice Patient Agreement

I understand that the concierge fee charged to me by Kriz Physical Therapy, P.A. is a **monthly membership fee not covered by any insurance carrier**. I understand that it is my responsibility to pay this fee in full prior to receiving treatment. Kriz Physical Therapy, P.A. will submit to my insurance carrier all charges for medically necessary treatment services in compliance with the insurance company practices.

Patient Name (PRINTED)

Date

Patient Signature