Kinetic Physical Therapy **PERSONAL INFORMATION**

FULL NAME: _____

NICKNAME: _____REFERRED BY:_____

ADDRESS:_____

CITY:_____ STATE_____ ZIP CODE_____

DATE OF BIRTH :_____ AGE :_____ GENDER: Male ___ Female____

MARITAL STATUS: Single___ Married___ Divorced___ Widowed ____

HOME PHONE:_____WORK PHONE:_____CELL PHONE:_____

(*Please circle number* if *you would like us to use for reminder calls*)

EMAIL ADDRESS (REQUIRED)_____

Please note that your email will not be shared and will only be used to update you on any changes in COVID protocols, weather cancellations and monthly articles and monthly articles we publish on various topics. You are free to unsubscribe at any time.

EMPLOYER NAME : _____ OCCUPATION:_____

PRIMARY CARE PHYSICIAN NAME: _____ PRIMARY CARE'S NUMBER_____

PERSON TO NOTIFY IN CASE OF EMERGENCY (relationship):_____ _____ PHONE:_____

IS THIS INJURY A RESULT OF A MOTOR VECHILE ACCIDENT? Y___ N__ PLEASE PROVIDE INFO

IS THIS A WORKERS COMPENSATION CASE? Y_____ N_____ PLEASE PROVIDE INFO

HAVE YOU RECEIVED PHYSICAL THERAPY SERVICES IN 2022? Y___N__PLEASE PROVIDE INFO

IF YOU ARE A MEDICARE PATIENT, PLEASE ASK US FOR INFORMATION ON THE MEDICARE PHYSICAL THERAPY CAP.

KINETIC PHYSICAL THERAPY, INC.

132 Holiday Court, Suite 203
Annapolis, MD 21403
(410) 573-9930

CONSENT FOR TREATMENT

I give my consent for Kinetic Physical Therapy, Inc. to evaluate and to provide physical therapy treatment as prescribed by my physician. (Signature needed below)

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Kinetic Physical Therapy, Inc.. A photocopy of this assignment is to be considered as valid as the original. I authorize said assignee to release all information necessary, including all medical records. This authorization remains until I revoke it in writing.

I am aware that I am responsible for any deductibles and/or co-insurance amounts as specified in my insurance plan. In addition I am aware that I am responsible that in the event that my insurance denies payment that I am responsible for payment of my bill.

(Please note that Kinetic Physical Therapy submits claims to your insurance company as a courtesy. We will re-submit a claim in the event of denial only one time.)

I understand that if I have a secondary insurance that is not set up as an automatic crossover plan, Kinetic Physical Therapy will not bill that secondary plan. I, the patient, am responsible for that portion of the bill.

Patient:_____
(PRINT)

Signature:_____ Date:_____

Agreement/authorization by responsible party if patient is a minor

Name of responsible party:_____

Relationship to patient:_____

Signature:_____

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CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of your protected health information
Your protected health information will be used by Kinetic Physical Therapy, Inc. or disclosed to others for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations of the practice.

Notice of privacy practices
You should review the notice of private practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a restriction on the use or disclosure of your information
You may request a restriction on the use or disclosure of your protected health information.

Kinetic Physical Therapy may or may not agree to restrict the use or disclosure of your protected health information.

Kinetic Physical Therapy agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of the consent is received will not be affected.

Reservation of right to change privacy practices
Kinetic Physical Therapy reserves the right to modify the privacy practices outlined in this notice.

Signature
I have reviewed this consent form and give my permission to Kinetic Physical Therapy to use and disclose my health information in accordance with it.

_____
Name of Patient (Print)

_____
Signature of Patient

_____
Date

_____
Signature of Patient representative

_____
Relationship of patient representative to patient

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NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Uses and disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professional for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Kinetic Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional uses of information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may be of interest to you.

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Individual rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of you protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Kinetic Physical Therapy duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise privacy practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to inspect protected health information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Stephen Sodero, MSPT, President of Kinetic Physical Therapy.

Complaints
If you would like to submit a comment or a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Stephen Sodero, MSPT
Kinetic Physical Therapy
132 Holiday Court, Suite #203
Annapolis, MD 21401

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date
This notice is effective on or after November 1, 2004.

Cancellation Agreement

Kinetic Physical Therapy requires a 24 hour notice for the cancellation of a scheduled appointment. There will be a $25.00 charge for a no-show or cancellation without proper notice. We understand that circumstances may occur such as illness or dangerous weather conditions, which is why we have implemented a "3 strike" policy. We will allow 3 missed appointments without proper notification before the fee will be assessed. Your treatment sessions are essential for positive outcomes and essential for you to meet you rehab goals. Repeated missed appointments will hinder your care and may prevent you from reaching your goals.

Patient Signature: _____ Date: _____

Iontophoresis Policy

Please be advised that the patient will be responsible for a $8.50 surcharge for the iontophoresis pads (each visit). This is an optional modality used to treat plantar fasciitis and tendonitis/bursitis near joints (ankle, elbow, shoulder, etc). You will also need to get a prescription from your doctor for dexamethasone, which will be filled at your pharmacy.

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Medical History Questionnaire

Please tell us about yourself. Check next to and list the details that apply to you:

- □ High Cholesterol
- □ High/Low Blood Pressure
- □ Varicose Veins
- □ Lung Disease
- □ Coughing up Blood
- □ Shortness of Breath
- □ Cough/Sputum
- □ Back Injury
- □ Back Pain
- □ Neck Pain
- □ Awaken at night - Urination
- □ Smoke
- □ Pregnant
- □ Pacemaker

- □ Heart Attack
- □ Heart Disease
- □ Chest Pain/Discomfort
- □ Rheumatic Fever/Heart Murmur
- □ Cancer
- □ Epilepsy
- □ Diabetes
- □ Gout
- □ Stroke
- □ Arthritis
- □ Surgeries/Operations (please list)

_____
_____
_____

□ Orthopedic Problems (please list)

_____
_____
_____

□ Physical Activity /Limitations

_____
_____
_____

Medications (prescription/non-prescription/supplements):

Name	Dosage (mg, ml)	Frequency (x/day)	Route (oral, injection, drops)

Weight _____ Height _____