KINETIC
PHYSICAL THERAPY

Kinetic Physical Therapy Office Policies

Thank you for choosing Kinetic Physical Therapy Physical Therapy. We are honored and committed to providing you and your family with the highest quality of patient care possible!

How did you hear about Kinetic Physical Therapy? _____

PATIENT NAME_____ Patient Date of Birth_____

Home Address _____

City_____ State_____ Zip Code _____

Phone Number (_____)_____- _____ Email Address: _____

Please list your health insurance plans:

Primary_____Secondary_____Teritiary_____

We highly recommend that you call your insurance to verify your Physical Therapy benefits.

Consent for Care and Treatment

I give my consent for treatment by the staff at KINETIC PHYSICAL THERAPY for physical therapy services and necessary treatment considered medically necessary as prescribed by my physician.

I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at KINETIC PHYSICAL THERAPY.

Signature _____Date_____

Benefit Assignment/Release of Information

I hereby authorize assignment of my insurance benefits to be paid directly to **KINETIC PHYSICAL THERAPY** for medical benefits to which I am entitled, including Medicare, private insurance, and third-party payers for services performed during the course of my treatment.

I authorize Kinetic Physical Therapy to release all information necessary including medical records to secure payment for Physical Therapy services provided by Kinetic Physical Therapy staff.

Signature _____Date_____

RELEASE OF INFORMATION: ***We are legally required to follow privacy practices. Please list who we have your permission to disclose any of your Medical Information with other than your referring Physician that has ordered your Physical Therapy.***

I hereby authorize Kinetic Physical Therapy to release and disclose all Medical History to:

Name:_____Relationship to patient: _____

Name:_____Relationship to patient: _____

I authorize Kinetic Physical Therapy staff to leave any voice messages regarding appointments and or medical information when medicallynecessary to the following phone numbers (___)_____-_____and (___)_____-__

TEXT MESSAGING CONSENT: I consent to receiving text messages from Kinetic Physical Therapy to wireless number (_____)

_____- _____. ***Text messages to the wireless number provided will include appointment reminders.***

EMAIL CONSENT: I consent to receiving email messages from Kinetic Physical Therapy to the following email address _____@_____._____***Email messages will include appointment reminders.***

I also understand that I have the right to terminate this authorization at any time in writing or verbally.

_____ _____ _____

Patient Name (Printed) Signature Date

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Have you had any Physical Therapy or Speech Therapy in the current c/year? **Yes** or **No** If **yes**, #visits?____Staff initial ____

Are you currently employed? YES or NO Are you on disability? YES or NO
Did you sustain an injury while at work? YES or NO Are your injuries related to an accident (i.e. is the patient being treated for an injury for which another party could be liable)? YES or NO

Financial Responsibility

- As a courtesy, every effort will be made by Kinetic Physical Therapy to verify your Out Patient Physical Therapy Benefits and all servicesand procedures verified and preauthorized by your health insurance company.
- It is the patient's responsibility to notify Kinetic Physical Therapy's Billing Department if at any time there is an insurance change.
- Payment is due at each visit as determined by your Insurance plan contractual benefits
- Patient full responsibility will be determined once your claims are processed for payment by your insurance company with an Explanation of Benefits (EOB) mailed out every 30 days and *it can be* a forwarded balance that is *different* from the **estimated** amount collected at each time of service.
- These quoted benefits are not a guarantee of payment and are an estimate provided by your insurance provider.
- If you have a Secondary or Tertiary insurance, we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- Patient is responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage or if deemed medically unnecessary by your insurance provider.
- If you the patient have received any other healthcare interventions/muscle manipulations that utilize any of your Physical Therapy visit limitations that are still pending payment with your insurance carrier, if your insurance contract has changed during treatment/mid-treatment or after you have been discharged while previous claims are still pending with your insurance you will responsible for the balance due for PT services. Other Healthcare Interventions that some insurance providers may bill under PT benefits might include the following but is not limited to: Out Patient/In Patient Physical Therapy • Occupational/Speech Physical Therapy • Chiropractic Services • Arrosti • Home Health Care (See Home Health Care Policy) • Muscular Manipulations
- It is the patient's responsibility to know if an Insurance Authorization is **REQUIRED** prior to receiving treatment and during treatment in order to continue to receiving additional Physical Therapy services and that an authorization is on file with Kinetic Physical Therapy. HMO and Health Maintenance Insurance plans require that an authorization is approved before a patient can be seen for treatment. Most Authorizations are not placed by Kinetic Physical Therapy Physical Therapy. Authorizations are placed by a patient's Primary Care Physician whose name will appear on the patients' Insurance card and we work with the physician's office as muchas they will allow for us to assist them in this effort on your behalf.
  - If your Insurance Maximum Benefit Limitations have been met/satisfied any time before/during/or after treatment with claims still pending, service amount will reflect in full charges due based on your contracted rate.
  - All past due balances must be paid prior to receiving any treatment.
  - If a payment is made in the form of a check and the check is dishonored or returned for any reason there will be a processing fee of $40.00 per check *plus* the original amount of each check.

At Kinetic Physical Therapy Physical Therapy, we all take great pride in what we do, and we love what we do! It is with this great passion thatit is our mission to develop a provider and patient relationship with our patient's best needs in mind. With each patient that we meet,we look forward to them experiencing the Kinetic Difference!

We look forward to taking great care of YOU on your road to recovery!

By signing below, you acknowledge having read this form in its entirety and fully understand your financial responsibilities as a patient.

Patient Name (Printed) _____ Signature _____ Date _____

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Home Health Care

Are you currently receiving **any** medical treatment by a **Home Health Care Agency** or any **Other Medical Staff** at **Home** including Hospice? **Yes** or **No** Staff Initial____

If your answer above is YES:
Please bring this information to the attention of a Kinetic Physical Therapy employee and your Treating Physical Therapist,as you may have to rearrange your Physical Therapy treatment.

Home Health Care Services/ Hospice Agency Name: _____
Telephone Number:_____**Last Date of Service at your House:** _____

Appointments

- **Our goal is to offer a variety of appointment times to meet the needs of our patients and their busy schedules.** One of our staff members will accommodate you as soon as possible.
- Children under the age of 18 must have a parent or guardian in our office during the Initial Evaluation and then is up to the discretion of the parent, patient and physical therapist if a parent is to be present for follow appts in its entirety.

Cancellation/No Show Policy

Your patient care is very important to us! If you miss or no show an appointment, we will definitely worry about you and want to know if you are Okay! If you need to cancel, change/edit any scheduled appointments please call us at 817-498-8585. We request that you provide us a **24Hr** business hour notice so we can reschedule your appointment within the same work week so you can continue onto your road to recovery, and avoid having to pay your **$25.00 Cancellation/No Show Fee** at your next therapy visit. If you find that you need to call us over a weekend, please leave us a message and team member will follow up with you on the next business day!

We appreciate your recognizing our policy so we can continue to provide Excellent World Class Service to all of our patients!

_____ _____ _____
Patient Name (Printed) Signature Date

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient rights and responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician, and facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, culture, physical handicap, personal values or belief systems.

THE PATIENT HAS THE RIGHT TO:

- Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary, cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including privacy in treatment and care. In addition, all communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment.
- Be fully informed of the scope of services available at the facility.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's designated representative of other legally designated person shall exercise the patient's rights.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third-party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time in a respectful manner to appropriate personnel.
- Change primary or specialty physicians or dentist if other qualified physicians or dentists are available.--DELETE
- Have an advance directive, such as a living will or healthcare proxy. A patient who has an advance directive must provide a copy to the facility and his or her physician so that his or her wishes may be known and honored. --DELETE
- Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

THE PATIENT IS RESPONSIBLE FOR:

- Being friendly, considerate and respectful of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her
- Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
- Promptly fulfilling his/her financial obligations to the facility.

X_____

Signature Date

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HIPPA CONSENT

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 the 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 physicians certifications.

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 to obtain a current copy of this 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 restriction, 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.

Patient Name:_____

Signature of Patient or Responsible Party:_____

Relationship to Patient: _____Date:_____

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PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Referring Physician: _____

Family Physician: _____

Date of First Doctor Visit for this Injury_____

Have you had any of the following Medical or Rehabilitative Services for ***THIS INJURY/EPISODE?***

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other: _____

Do You Have or Have You Ever Had Any of the Following?

	YES	NO		YES	NO
Asthma, Bronchitis	___	___	Severe or frequent headaches	___	___
Angina	___	___	Emphysema	___	___
Shortness of breath/chest pain	___	___	Vision or hearing difficulties	___	___
Coronary Heart Disease	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight loss/Energy loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemo/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/ Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are you pregnant?	___	___
Emotional/Psychological Dx	___	___	Do you use Tobacco?	___	___

Patient/Guardian Signature: _____ Date: _____