



## KCP Physical Therapy New Patient Forms

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### PATIENT INFORMATION

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email \_\_\_\_\_

Patient's Status: Married / Single / Other      Employed / Student / Other

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone # \_\_\_\_\_

\*\*\*\* PLEASE HAVE YOUR INSURANCE CARD AVAILABLE \*\*\*\*

#### Financial Policy

I understand that KCP has verified my benefits as a courtesy to me. This authorization is not a guarantee of payment. Any deductible, Co-pay or Co-insurance will be collected at the time of service. At the end of my treatment my chart will be reviewed. Any inaccurate information provided by my insurance company regarding deductible, copay or coinsurance that results in an outstanding balance due would be my responsibility. Refunds will be issued as appropriate.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have "Automatic Crossover" on your Medicare policy? \_\_\_\_\_ YES \_\_\_\_\_ NO  
(Automatic Crossover means that Medicare forwards your claim to your secondary insurance policy)

### PATIENT TREATMENT INFORMATION

How did you hear about us?

What are we seeing you for? \_\_\_ Neck \_\_\_ Back \_\_\_ Upper Extremity \_\_\_ Lower Extremity

General Symptoms \_\_\_\_\_





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### CLIENT CONSENT FOR EVALUATION AND TREATMENT

I hereby authorize evaluation and treatment by KCP Physical Therapy. My signature below reflects my consent for treatment.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent for Assignment of Benefits

I hereby authorize KCP Physical Therapy to bill my insurance company and for my insurance company to remit payments to KCP Physical Therapy for services rendered.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent to Release Medical Information

I hereby authorize KCP Physical Therapy to release any medical information pertaining to my care to my physician or other medical service providers and to my insurance company. I also authorize KCP Physical Therapy to receive any pertinent information from my physician or other medical service providers.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### No Show and Cancellation Policy

Please be advised that KCP Physical Therapy requests a 24 hour notice of cancellation as a courtesy to us and our other clients. Failure to cancel an appointment will result in a \$50.00 no show fee.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### HIPPA Privacy Practice Notification

I agree that I have been informed and been given a choice to receive a copy of the HIPPA privacy practices for KCP. I fully understand that I am in no way to discuss any information I hear or see about a patient or client that I may observe while being treated at KCP. For full details of this act please read the HIPPA form that will be presented to you upon your initial visit.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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### HEALTH STATUS QUESTIONNAIRE

Please complete each question accurately. All information provided is confidential.

#### INDIVIDUAL INFORMATION

Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Approximately when was your last physical? \_\_\_\_\_

Occupation: \_\_\_\_\_

#### MEDICAL HISTORY

Have you had orthopedic surgery in the past? ..... Yes No

Do you have a pacemaker? ..... Yes No

Are you diabetic? ..... Yes No

Do you or have you been treated for breast cancer? ..... Yes No

Do you or have you been treated for prostate or any other cancer? ..... Yes No

If other, what type and when? \_\_\_\_\_

Have you had a sudden change in weight? Loss Gain How many pounds? \_\_\_\_\_

Do you have pain that awakens you at night? ..... Yes No

Please list any medications you are taking or have taken over the last six months:

\_\_\_\_\_

Do you exercise regularly? Yes No How often? \_\_\_\_\_

Have you had Physical Therapy for this or any other problem before? ..... Yes No





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**KCP PHYSICAL THERAPY IS COMMITTED TO  
PROVIDING SPECIAL ACCOMMODATIONS  
FOR ALL PATIENTS.**

**KCP PHYSICAL THERAPY AGREES TO  
PROVIDE EFFECTIVE COMMUNICATION  
AND INTERPRETERS UPON REQUEST.**

**PLEASE CALL US IMMEDIATELY IF THESE  
SERVICES ARE NEEDED.**

**PHONE: 704-541-1191**

