KCP Physical Therapy
New Patient Forms

PATIENT INFORMATION

Patient Name _____ DOB _____

Patient's Address _____

City _____ State_____ Zip Code_____

Home Phone # _____ Work Phone # _____

Cell Phone #_____ Preferred Phone #(to leave message)_____

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. I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

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

What are we seeing you for? ___ Neck ___ Back ___Upper Extremity ___ Lower Extremity

Current injury _____ Onset date _____

Previous Treatment _____

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 QUESTIONAIRE

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

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