PHYSICAL THERAPY • FITNESS • WELLNESS

Patient Information

Patient Name:_____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____Phone Number: _____

Email: _____

Emergency Contact: _____

Relationship: _____ Phone Number:_____

Current Injury

Briefly describe your current injury:

_____

_____

Previous treatment for this condition? _____

_____

Previous Orthopedic Surgery? _____

Health History

Diabetes? ☐ Yes ☐ No

Breast Cancer? ☐ Yes ☐ No

Prostate Cancer? ☐ Yes ☐ No

Pacemaker/ICD? ☐ Yes ☐ No

Pain that awakens you at night? ☐ Yes ☐ No

Implants? ☐ Yes ☐ No
If yes, where? _____

Sudden change in weight? ☐ Yes ☐ No

Regular exercise routine? ☐ Yes ☐ No
Please describe_____

Current Medications:_____

_____

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CONSENT FOR TREATMENT

Thank you for choosing KCP Physical Therapy, (KCP PT). KCP PT accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurance companies pay a predetermined amount of our treatment charges; however, *it is your responsibility to call your insurance company to check on the coverage provided by your individual policy*. As a courtesy to you, we will perform an insurance verification with your insurance company; however, *we do not take responsibility for any misinformation that we are given during this process. It is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm with our office prior to initiating treatment.* _____ *(initial)*

CONSENT FOR CARE AND TREATMENT

Physical therapy is a healthcare specialty focused on the evaluation, diagnosis and treatment of conditions that limit an individual's ability to move and function in their daily life. Physical therapists use a combination of hands-on techniques exercise and modalities to help alleviate pain, improve mobility and restore function.

It is important to note that physical therapy is a not a one size fits all approach and each patient's treatment plan is individualized to their specific needs and goals. Physical therapists work closely with patients to develop a plan of care that takes into consideration their medical history, current symptoms and functional limitations.

Response to physical therapy intervention varies from person to person; hence it is not possible to accurately predict your response to a specific procedure, exercise protocol or modality. Our physical therapists do not guarantee what your reaction will be to a specific treatment, nor do they guarantee that the treatment will help resolve the condition for which you are seeking treatment. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment should you feel any discomfort or pain or have other unresolved concerns.

It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms and examination results.

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Consequently, it is your right to discuss the potential risks, and benefits involved in your treatment. If you have any questions or concerns about physical therapy, it is recommended that you discuss them with your physical therapist or healthcare provider. I understand that physical therapy is a treatment for various conditions, including but not limited to, pain, weakness and limited mobility. Physical therapy may involve manual therapy, exercises modalities and other treatments deemed necessary by my physical therapist.

I acknowledge that physical therapy may cause temporary discomfort or soreness and I assume the risks associated with physical therapy treatment. I understand that I am responsible for communicating any discomfort or pain to my physical therapist.

I hereby authorize KCP PT to release any information regarding my physical therapy treatment to my physical an or other healthcare providers as deemed necessary

I acknowledge that I have been informed of my rights as a patient receiving physical therapy and have had to opportunity to asks questions and receive answers to my satisfaction

Accordingly, I release, waive, discharge and covenant not to sue KCP PT, any of its employees, representatives, officers, directors, shareholders, affiliates, administrators, agents, owners, or lessors of all equipment, all of whom are hereafter referred to as "Releasees", from demands, losses, or damages on account of injuries, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the Releasees or otherwise. _____*(initial)*

FINANCIAL RESPONSIBILITY

I understand that in some instances my health insurance may not cover all treatment charges incurred. I agree to be financially responsible to KCP PT for any medically necessary therapeutic services that are not covered by my health insurance carrier. In addition, I authorize KCP PT to release (a) any medical or other information about PT services, or services provided by third parties, if required to obtain payment from my insurer or other payer and their agents to process payments; (b) any medical or other information required by my insurer, other payers and their agents; and (c) medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me. I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payor authority for any reason on my behalf. I personally will be active in the resolution of claims delay or unjustified reductions or denials. _____*(initial)*

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ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to KCP PT any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by KCP PT for treatment. By way of my signature below, I provide KCP PT with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices. _____*(initial)*

CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES

I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit, according to my insurance benefits and the following KCP PT policy to reduce the balance billed to me at the end of care: Copays are collected in full at the time of service. Remaining balances that have been applied toward your deductible and coinsurance will be collected as insurance(s) processes these claims throughout the course of treatment. Any outstanding balances due at the end of each month will be billed to the patient. _____ *(initial)*

NO SHOW CANCELLATION POLICY:

Please understand that appointment times are limited. If you must cancel your appointment, as a courtesy to KCP Physical Therapy, a 24 hour notice is required. Failure to cancel in a timely manner will incur a $75.00 fee. Second late cancelation or No Show, you will receive written notice and a $75.00 fee. Third late cancellation or no show, you will be required to schedule on the same day for the appointment and will pay $75.00 to hold your appointment. After three last minute No Show or Cancellations, KCP reserves the right to discharge the patient from the practice._____ *(Initial)*

PATIENT VALUABLES

I relieve KCP PT of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that KCP PT will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS, FINANCIAL RESPONSIBILITIES AND OTHER HEALTHCARE COMMUNICATIONS

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I consent to receive calls/texts/emails from KCP PT regarding my patient health information, statements, and other services at the phone number(s) or email addresses listed, including my provided wireless number. These calls/texts/ emails may include information such as appointment dates and times as well as other financial responsibilities due and other pertinent information. I understand I may be charged for such calls/texts by my wireless carrier. I understand that I can revoke consent to receive such calls/texts/emails at any time by opting out. _____*(initial)*

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)_____ I am entitled under State Law to consent to medical or other health services for myself, and if applicable, for my minor children without the consent of any other person: _____ *(Initial required if completing this section)*

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

FOR KCP PHYSICAL THERAPY OFFICE USE ONLY

Verification of the identity of the above-named party was made by:

- Current Driver's License or other Photo ID
- current Health Insurance Card
- other:

I have read this Consent for Treatment and Financial policy form or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date of signature.

_____ _____

Signature of Patient or Guardian (if patient is a minor) Date

Rev 6/23

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TRIGGER POINT DRY NEEDLING CONSENT

Dry needling is a treatment performed by skilled, trained physical therapists. A thin monofilament needle penetrates the skin and treats underlying muscular trigger points for the management of neuromusculoskeletal pain and movement impairments. The goal is to reduce pain, inactivate trigger points and restore function (Def. Mayo Clinic).

Risks are minimal but may result in injury to a blood vessel and bruising. You may experience the sensation of a small prick at the time of insertion. During treatment when the trigger point is located, you may experience throbbing, aching, burning, or tingling.

Trigger point dry needing is a fee for service procedure.

I understand that KCP Physical Therapy will not bill my insurance company for this procedure:

Client Signature:_____ Date:_____

NEW CLIENT POLICY DRY NEEDLING:

Due to the time required to render dry needling services, all new Trigger Point Dry Needling patients are required to provide a deposit of $100.00 to schedule an appointment. This deposit will be used toward your dry needling fees. A 24-hour notice is required for all cancellations. All clients must reschedule within one week, failure to adhere to this policy will result in loss of the deposit.

Client Signature_____ Date:_____

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Notice of Protected Health Information Practices (Privacy Policy)

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.

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), PHOENIX Rehabilitation and Health Services, Inc. ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. Uses and Disclosures with Patient Consent: Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

a. Treatment. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.

b. Payment. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

c. Health Care Operations. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. Uses and Disclosures With Patient Authorization. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such

revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.
3. Uses and Disclosures With Patient Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.
4. Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:
a. Uses and Disclosures Required by Law. We will disclose your health information when required to do so by law.
b. Public Health Activities. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and
similar other circumstances.
c. Abuse and Neglect. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.
d. Regulatory Agencies. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.
e. Judicial and Administrative Proceedings. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.
f. Law Enforcement Purposes. We may disclose your health information to law enforcement officials when required to do so by law.
g. Coroners, Medical Examiners, Funeral Directors. We may disclose your health information to a coroner or medical examiner. This may be necessary,
for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.
h. Research. Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.
i. Threats to Health and Safety. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
j. Military/Veterans. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. Workers' Compensation. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. Marketing. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.
m. Appointment Reminders. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.
n. Other Uses and Disclosures. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.
5. Uses and Disclosures to Business Associates. With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:
1. Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.
2. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your own health information upon request; it may be in electronic or paper format. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.
3. Right to Verbally Object. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.
4. Right to Seek an Amendment of Your Health Information. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. Right to an Accounting of Disclosure of Your Health information. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.
6. Right to Confidential Communications. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.
7. When Authorizations are Required. An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.
8. Right to Revoke Your Authorization. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.
9. Right to Opt-Out of Fundraising Communications. We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications. You can do so in writing by calling the Compliance Officer at (724) 343-4060 x134 or sending an email to tgiannetta@phoenixrehab.com with your instructions to opt out of fundraising communications.
10. Right to be Notified Following a Breach of Your Information. If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.
11. Right to Receive Copy of this Notice. You have the right to receive a copy of this Notice.
Contact Information and How to Report a Privacy Rights Violation
If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at (724) 343-4060 x134. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact our Compliance Officer at (724) 343-4060 x134. All complaints must be submitted to the Practice in writing at 430 Innovation Drive, Blairsville PA 15717. There will be no retaliation for filing a complaint.

Effective Date 6/5/2023

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As a patient of KCP Physical Therapy, you have the right to:

1. Receive respectful and compassionate care regardless of race, creed, gender, sexual orientation, national origin, or health status in a safe environment.

2. Be knowledgeable of the members and roles of your healthcare team.

3. Receive treatment by qualified personnel possessing the level of skill needed for the required care.

4. Receive information concerning your diagnosis, treatment and prognosis that is accurate and easy to understand.

5. Be involved in the planning of care regarding treatment interventions and goals.

6. Receive reasonable communications regarding treatment progress, changes to the treatment plan, and discharge plans.

7. Have the right to expect that all communication and records pertaining to your medical information should be treated as confidential as outlined in the Notice of Privacy Practices.

8. Reasonable continuity of care with minimal interruption.

9. Receive treatment interventions that are safe and specific to your needs.

10. Refuse care in general, or specific treatment interventions, at any point during your treatment and be informed of the associated consequences.

11. Receive communication in a language or manner in which you can understand. This includes communication assistance, such as sign language and foreign language interpreters, as well as vision, speech and hearing assistance at no charge to you.

12. Expect emergency procedures to be implemented without unnecessary delay when required.

13. Receive a prompt and comprehensive response to billing inquiries or general concerns regarding the quality of care.

14. Report problems or complaints about the care received.