Kinetic Orthopaedic Physical Therapy
1950 Sawtelle Blvd, Suite 190, Los Angeles, CA 90025
(310) 312-5678 | info@kineticpt.net

PATIENT INFORMATION

Today's Date:____________________

Name:____ SS#:________-________-________
First MI Last (REQUIRED FOR WORK COMP & VA ONLY)

☐ Male ☐ Female Date of Birth____/____/____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:____
Street Address City State Zip

Email Address:____Fax: (______) ______-______________

Would you like to receive appointment reminders by email? ☐ Yes, notify me by email ☐ No, Do not email me

Home Phone: (______) ______-____________ ☐ Work or ☐ Cell Phone: (______) ______-____________

Would you like to receive appointment reminders by text? ☐ Yes, notify me by text ☐ No, Do not text me

Driver's License #:____________________________State Issued:_______ **Please provide a copy for our records**

Employer:____ Occupation:______________________________
(REQUIRED FOR WORKER COMPENSATION CASES)

Emergency Contact:____________________________ Phone: (______) ______-____________Relation:____________

Have you had Physical or Occupational Therapy this year for any condition? ☐ Yes ☐ No

PHYSICIAN INFORMATION

Referring Physician:____Date of Injury:____________________

Office Address:____Phone: (______) ______-____________
Street Address City State Zip

APPOINTMENT POLICY

I understand that my doctor has prescribed physical therapy for me and physical therapy is an on-going process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three (3) consecutive appointments, Kinetic Orthopaedic Physical Therapy has the right to discharge me from care for being non-complaint with my physician's orders.

I understand and agree that **Kinetic Orthopaedic Physical Therapy** requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $50 charge (which is not covered by insurance)

Signature:____ Date:__________________________
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

CONSENT FOR TREATMENT

I the Undersigned do hereby agree and give my consent for **Kinetic Orthopaedic Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition. I also authorize Kinetic Orthopaedic Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Signature:____ Date:__________________________
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

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FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. If I do not provide insurance information or inaccurate information, Kinetic Orthopaedic Physical Therapy will bill me directly for incurred charges, as well as for charges not covered by my insurance plan. If I receive a notice from my insurance company that payment is delayed or denied because additional information is required, I will contact my insurance company so that claims may be reprocessed and paid.

I hereby give authorization for payment of insurance benefits made directly to KOPT for services rendered. In the event that my insurance company forwards payment directly to me, instead of KOPT, I will immediately deliver said payment to KOPT.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand and agree that if it becomes necessary to commence legal actions for the collection of outstanding charges on my account, I will be responsible for any costs and/or court fees, in addition to the outstanding balance.

Signature of Person Responsible for Charges:_______________________________________ Date:__________________
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

PRIMARY INSURANCE

Name of Subscriber:_____________________________________ ______________________Date of Birth____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other ________________________

Address of Subscriber:____
(If Different Than Patient) Street Address City State Zip

Home Phone: (______) ______-_____________ Cell Phone: (______) ______-______________ SS#:______-____-_______
(If Different Than Patient)

Insurance Co:____ Phone: (______) ______-_____________

Subscriber #:____Group#/Name:______________________________

Subscriber's Employer:____ Phone: (______) ______-_____________

SECONDARY INSURANCE

Name of Subscriber:_____________________________________ ______________________Date of Birth____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other ________________________

Address of Subscriber:____
(If Different Than Patient) Street Address City State Zip

Home Phone: (______) ______-_____________ Cell Phone: (______) ______-______________ SS#:______-____-_______
(If Different Than Patient)

Insurance Co:____ Phone: (______) ______-_____________

Subscriber #:____Group#/Name:______________________________

Subscriber's Employer:____ Phone: (______) ______-_____________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF RELEASE OF SPECIFIC INFORMATION

Patient Name:____ Clinic:___________________________________

Kinetic Orthopaedic Physical Therapy reserves the right to modify the privacy practices outlined in this notice.

I acknowledge that I have received or have had the opportunity to receive a copy of the official Notice of Privacy Practices from Kinetic Orthopaedic Physical Therapy.

Signature:____ Date:____________________________
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

Initial all statements that apply:

________ I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

________ I authorize you to discuss my appointments with my spouse as listed on my patient information.

________ In addition to my referring doctor, I authorize you to communicate with and send reports & evaluations to the following:

____

____

By signing this authorization, I understand that this does not authorize release of medical information by Kinetic Orthopaedic Physical Therapy to any other organization or agency unless I grant further authorization. I also understand that these authorizations may be revoked at anytime.

Signature:____ Date:____________________________
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

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CONTRACTUAL GUARANTEE OF PAYMENT FOR HEALTH CARE SERVICES

Patient Name:______________________________________ Clinic Location:_________________________

I fully understand that I am directly and fully responsible to Kinetic Orthopaedic Physical Therapy for all medical bills submitted by the clinic for services rendered me. Further, this agreement is made solely for said clinic's additional protection and in consideration of the company awaiting payment. I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages. **I also understand that my responsibility to pay my medical bill is independent and separate from Kinetic Orthopaedic Physical Therapy's right to file a lien to protect its financial interest under RCW 60.44.**

I hereby authorize and direct you, my attorney, to pay directly to Kinetic Orthopaedic Physical Therapy such sums as may be due and owing for health care services for injuries arising from a motor vehicle collision. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect said company. I hereby further consent to a lien being filed on my case by Kinetic Orthopaedic Physical Therapy against all proceeds of my settlement, judgment, or verdict, which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated in connection therewith.

I agree to never rescind this document and that any attempted rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor the Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I specifically request my attorney to acknowledge this letter by signing below and returning it to the therapy office. I have been advised that if my attorney does not wish to cooperate in protecting the clinic's interest, the company will not await payment, but will require me to make payments on a current basis.

____

Signature of Patient/Guardian Date

____

Patient's Driver's License Number

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Kinetic Orthopaedic Physical Therapy.

____

Signature of Attorney Date

Please sign, date and return to Kinetic Orthopaedic Physical Therapy.

Thank you.

Please return to this address:

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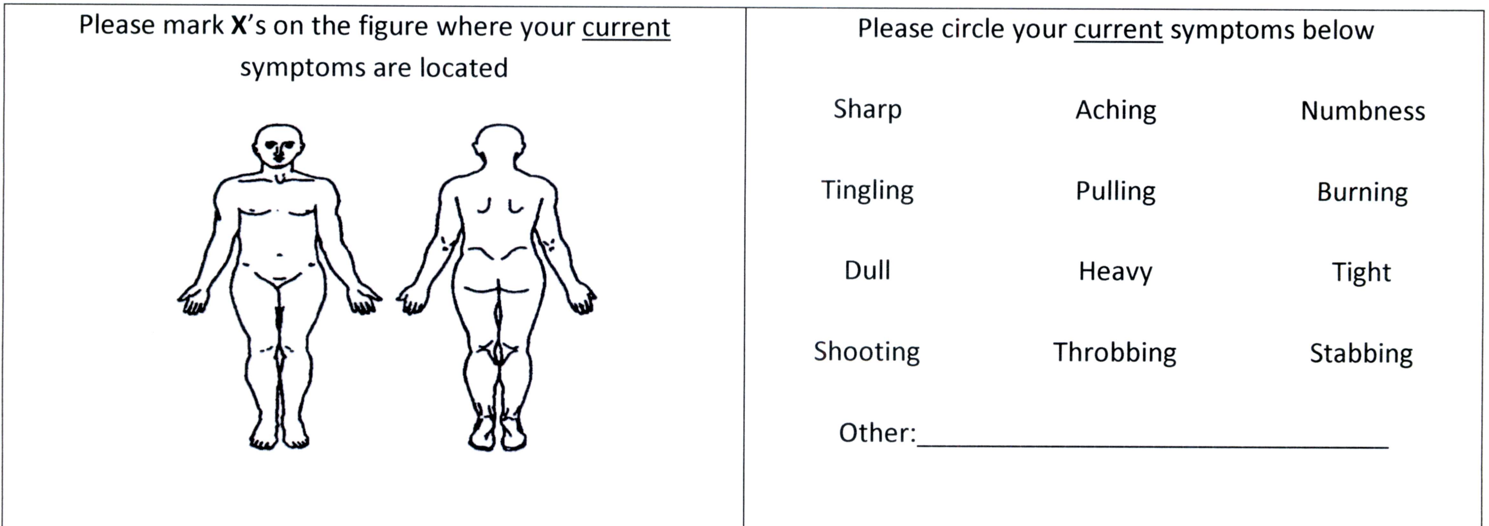
HEALTH HISTORY

Patient Name:____ Height____Weight_____ Date of Birth___/___/__

CURRENT COMPLAINTS

How and when did your injury/condition/surgery begin?____
What makes your pain increase?____
What makes your pain decrease?____
How long does it take for your pain to subside?____
Have you ever had a similar injury/condition in the past?____
Is your injury/condition **getting better**, **staying the same**, or **getting worse**? (Circle one)



Please mark **X**'s on the figure where your current symptoms are located

Please circle your current symptoms below

Sharp	Aching	Numbness
Tingling	Pulling	Burning
Dull	Heavy	Tight
Shooting	Throbbing	Stabbing

Other:________________________________

Rate your pain level over the last week at its best and at its worst on the scale below

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**

On the percentage scale below, circle your current level of overall function

NO RESTRICTIONS 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% **UNABLE TO FUNCTION**

Are you currently working? YES NO

Do you have any work restrictions? YES NO

Please specify any work restrictions given to you by your doctor

____
____

Please list any specific limitations you have due to your current symptoms

At Home: ____
At Work: ____
At Leisure: ____

Kinetic Orthopaedic Physical Therapy

David Pakozdi, PT, OCS • Joshua Hawkins, PT, DPT
1950 Sawtelle Blvd., Suite 190
Los Angeles, California 90025
310-312-5678, Fax: 310-231-0336

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Allergies	☐ Yes	☐ No	**Dizzy Spells**	☐ Yes	☐ No	**MRSA**	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	**Emphysema/ Bronchitis**	☐ Yes	☐ No	**Multiple Sclerosis**	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	**Fibromyalgia**	☐ Yes	☐ No	**Muscular Disease**	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	**Fractures**	☐ Yes	☐ No	**Osteoporosis**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	**Gallbladder Problems**	☐ Yes	☐ No	**Parkinsons**	☐ Yes	☐ No
Auto Immune Disorder	☐ Yes	☐ No	**Headaches**	☐ Yes	☐ No	**Rheumatoid Arthritis**	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	**Hearing Impairment**	☐ Yes	☐ No	**Seizures**	☐ Yes	☐ No
Cardiac Conditions	☐ Yes	☐ No	**Hepatitis**	☐ Yes	☐ No	**Smoking**	☐ Yes	☐ No
Cadiac Pacemaker	☐ Yes	☐ No	**High Cholesterol**	☐ Yes	☐ No	**Speech Problems**	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	**High/Low blood pressure**	☐ Yes	☐ No	**Strokes**	☐ Yes	☐ No
Circulation Problems	☐ Yes	☐ No	**HIV/AIDS**	☐ Yes	☐ No	**Thyroid Disease**	☐ Yes	☐ No
Currently Pregnant	☐ Yes	☐ No	**Incontinence**	☐ Yes	☐ No	**Tuberculosis**	☐ Yes	☐ No
Depression	☐ Yes	☐ No	**Kidney Problems**	☐ Yes	☐ No	**Vision Problems**	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	**Metal Implants**	☐ Yes	☐ No			

Describe any other conditions or precautions:

Fall History

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of falls:______________________________

Two or more falls in the last year? ☐ Yes ☐ No Dates of falls:______________________________

Surgical History

Body Region:____________________ **Surgery Type:**____________________ **Date of Surgery:**__________________
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Body Region:____________________ **Surgery Type:**____________________ **Date of Surgery:**__________________

Current Medications

Drug:__________________________ **Dosage:**______________ **Reason for Taking:**________________________
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