PATIENT INFORMATION

Date: ______________

Name: ____ SS#: _____-______-______

First Mi Last (REQUIRED FOR WORK COMP)

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

Home Address: ____

Street Address City State Zip

Email Address: ____

Would you like to receive appointment reminders by email? **YES** or **NO**

Preferred contact method: Home or Cell

Home Phone (____) ______-________ Cell Phone (____)______-________

DL #: ______________________ State Issued: ________ (Please provide a copy for our records.)

Emergency Contact: __________________ PH # (____)______-________Relationship: ____________

PHYSICIAN INFORMATION

Referring Physician: ______________________________ Phone (____)______-________

Office Address: ______________________________ Date of Injury: ____________

Street Address City State Zip

AUTHORIZATION FOR TREATMENT

I hearby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above by Kinematics Physical Therapy and Sports Performance, Inc.

Signature: ______________________________ Date: ________________

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to patient: MOTHER FATHER LEGAL GUARDIAN

WORKERS' COMPENSATION WORKSHEET

ALL FIELDS REQUIRED

Injured Worker's Name:______________________________ SS#______________

Date of Injury:___/___/___ Claim #:______________________________

AT TIME OF INJURY – Employer:______________________________

Employer's Address:______________________________

Street Address City State Zip Code

Employer's Phone: ______________________ Contact Person: ______________

WORKERS' COMPENSATION CARRIER & ATTORNEY INFORMATION

Carrier: ______________________________

Claims Mailing Address:______________________________

Street Address City State Zip Code

Adjuster's Name: ______________________________

PH:__________________ EXT:________ Fax:______________

Nurse Case Manager or Utilization Review Contact: ______________________

PH:__________________ EXT:________ Fax:______________

Attorney Name:______________________ PH:______________

Mailing Address:______________________________

Street Address City State Zip Code

FINANCIAL POLICY

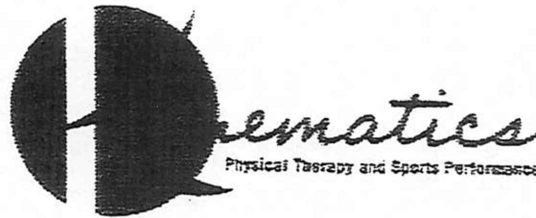
In the event, that my Work Comp claim is denied by the Workers' Compensation Carrier, Kinematics Physical Therapy will not transfer charges to an attorney lien that were assessed prior to the date the claim was denied. I understand and agree that I become the responsible party and liable for payment of all charges assessed for professional services rendered. I agree to pay any sum due, upon demand. I understand and agree that if it becomes necessary for Kinematics Physical Therapy to utilize an outside collection agency, or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance, and in addition, attorney fees, court costs and other expenses of litigation (plus a $50.00 processing fee).

ATTENDANCE / NON-COMPLIANCE NOTIFICATION

Your therapist, physician, adjuster/NCM work together it assist with your return to full function in the workplace. In order for your treatment to have the maximum effect and progress, all prescribed therapy sessions must be attended. To comply with the workers' compensation laws, we are required to notify the adjuster/NCM and physician of missed appointments. If for any reason you are unable to attend, we request that you call and try to give us a 24 hour notice and we can reschedule your visit. Missed appointments may result in discontinuation of workers' compensation benefits.

I have read and understand the financial policy and attendance/non-compliance notification. I do here by acknowledge that all information on this form is true and factual,

Patient Signature:______________________ Date:______________



DIRECT ACCESS DISCLOSURE

Direct Physical Therapy Treatment Services Disclosure

You (the patient) are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California. Your physical therapist is a professional employee in this physical therapy practice, which will bill your insurance company and/or the patient for professional physical therapy services recommended and administered by the PT only in the best interests of your personal health.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indication approval of the physical **therapist's** plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

With your written authorization, your physical therapist shall notify your physician and surgeon, if any, that he/she is treating you.

______________________________________ ____________________

Patient signature Date

1761 Third St., Ste. 105 * Norco, CA 92860 * (951) 777-2178 * Fax (951) 797-6855

Attendance Policy

In order to receive the most benefit from physical therapy, it is important that you follow the treatment plan prescribed by your physician and therapist and attend all sessions on a regular basis.

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 consecutive appointments, Kinematics Physical Therapy and Sports Performance has the right to discharge me from care for being non-compliant with my physician's orders.

We request that you give us at least 24 hours notice if you must cancel your appointment. Cancellations made with less than 24 hours notice and/or missed appointments will result in a $50 dollar charge which will be billed directly to you. Insurance companies will not cover missed appointment charges.

We appreciate your cooperation and thank you in advance for understanding.

The above information has been read by and explained to me. I understand my responsibility for the payment of any charges for cancelled or missed appointments.

Patient/Guardian:______________________________ Date:______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Kinematics Physical Therapy (The Company) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service w billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Kinematics Physical Therapy and agree to the liability limitations explained therein.

_____________________________   __________   ____________________

Signature of patient or legal representative   Date   Relationship to Patient

____

Printed name of patient

Medical History

Existing or Relevant Previous Conditions

Condition	Response	Condition	Response	Condition	Response
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
Autoimmune 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
Cardiac Pacemaker	◯Yes ◯No	High/Low blood pressure	◯Yes ◯No	Speech Problems	◯Yes ◯No
Chemical Dependency	◯Yes ◯No	High Cholesterol	◯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

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

☐ Injury as a result of a fall in the past year?

☐ Two or more falls in the last year?

Surgical History

Body Region: ____________ Surgery Type: ____________ Date: ______, ______, ______

Body Region: ____________ Surgery Type: ____________ Date: ______, ______, ______

Body Region: ____________ Surgery Type: ____________ Date: ______, ______, ______

Body Region: ____________ Surgery Type: ____________ Date: ______, ______, ______

Current Medications

Drug: ________ Dosage: ______ Frequency: ______ Route: ______ Reason Taking: ________

Drug: ________ Dosage: ______ Frequency: ______ Route: ______ Reason Taking: ________

Drug: ________ Dosage: ______ Frequency: ______ Route: ______ Reason Taking: ________

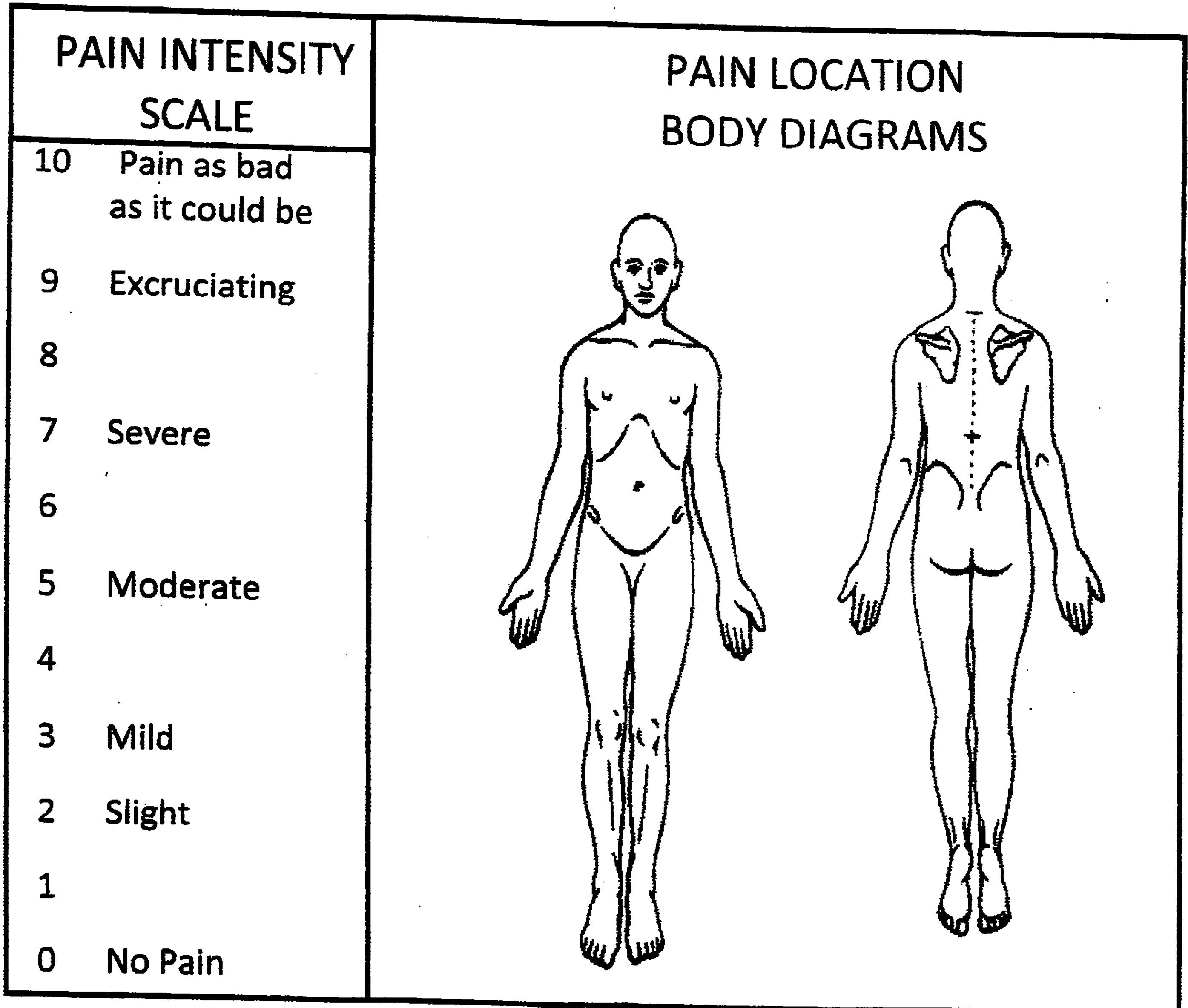
Drug: ________ Dosage: ______ Frequency: ______ Route: ______ Reason Taking: ________

☐ Currently not taking any medications

Kinematics

Physical Therapy and Sports Performance

Graphic Pain Assessment



PAIN INTENSITY SCALE	PAIN LOCATION BODY DIAGRAMS
10 Pain as bad as it could be	
9 Excruciating	
8	
7 Severe	
6	
5 Moderate	
4	
3 Mild	
2 Slight	
1	
0 No Pain	

1. **Draw a line on the pain intensity scale at the point that best describes your pain at the present time.**
2. **Draw the location of your pain on the body diagrams above.**
3. **If you have any other symptoms, such as tingling or numbness, draw these as a dotted line.**

Please describe the details of your injury, including the date of injury and any treatment of the injury: