

PATIENT INFORMATION

Today's Date: _____

Name _____ Birth Date _____ Gender _____ Nickname _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #'s: Home () _____ Cell () _____ which is preferred # Home/Cell?
Employer _____ Occupation: _____ Work () _____ Ext _____

As a courtesy we will try to give you a reminder call a couple of days before your scheduled appointment. Is it okay to leave a message on the number(s) you indicated? ___ Yes ___ No (or) ___ I would prefer not to receive a reminder call.

(Optional) e-mail address: _____ (newsletters, alerts, articles)

Emergency contact: spouse/child/parent/sibling/partner/friend _____, at # _____
(Circle one) (Name) (Phone #)

Doctors * These doctors will be sent notes about your progress unless you indicate otherwise.

Primary: _____ of _____ at _____,
(Name) (Practice/Group name) (Location) (Phone #)

Referring: _____ of _____ at _____,
(Name) (Practice/Group name) (Location) (Phone #)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Kulp Physical Therapy and Massage at 1331 E. Victor Road Victor, NY 14564, to disclose and/or obtain my protected health information, to/from my primary and/or referring physician's office (indicated above) unless/until I request otherwise. I also authorize, on an as needed/by request basis only, the following individual(s), family member(s), Entity, or contact person(s). "Other" includes persons I want the ability to make/cancel/confirm appointments on my behalf.

Spouse/Partner _____ Other _____
Other _____ Other _____

Information to be released includes but may not be limited to; Medical History, Treatment, Tests, Progress Notes, Disabilities, Prescriptions, Appointment Record, Consultations, Referrals, and/or Radiology Reports.

I understand that I have the right to; Receive a copy of this authorization, Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization. I understand that I have the right to; Revoke this authorization, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect: **CHOOSE ONE:** _____ Indefinitely _____ until I request otherwise
until the following date: _____

ACKNOWLEDGEMENT OF REVIEW/RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed and understand Kulp Physical Therapy's Notice of Privacy Practices (HIPAA). I can have a copy for my records at any time I request. This notice describes the responsibilities of and how Kulp Physical Therapy and Massage may use and disclose my protected health information (PHI), certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

CONSENT FOR ASSESSMENT AND TREATMENT

I understand that as a patient of Kulp Physical Therapy and Massage the type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. If I have any questions regarding this consent or about the services offered/performed I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Kulp Physical Therapy and Massage. I understand that I may stop treatment at any time.

Signature is an authorization you accept the terms stated above. A copy of this signature is as valid as the original.

Signature _____ Parent/guardian must sign if the patient is under 18

Date _____

Print name _____

Relation to Patient if other than self _____

INSURANCE INFORMATION

Are you currently receiving ANY home health services? (Visiting Nurse, Home Health Aide, or hospice) ___no ___ yes*
(it doesn't have to be physical therapy or even related to why you are getting physical therapy)

***If yes, treatment may not be covered by your insurance plan, please speak with Management asap.**

Were you injured: At work? No/Yes* In an auto accident? No/Yes* At a business and filed a liability claim? No/Yes*

***If yes: Please complete our accident form**

We need a copy of your health insurance card(s) so please be prepared to provide them at each appointment

Primary Insurance: BC/BS, EXCELLUS, MVP, MEDICARE, AETNA, UNITED HEALTHCARE, CIGNA, TRICARE

OTHER: _____ ****MANY PLANS HAVE SPECIFIC PLAN COVERAGE CRITERIA THAT MUST BE FOLLOWED**

Subscriber's Name: _____ Relation: _____ Subscriber's Date of Birth: _____

Does your plan require a (please circle all that apply): co-pay co-insurance high-deductible

Does your plan require a referral or preauthorization? ___ No ___ Yes ___ Unsure*

**It is the patient/insured's responsibility to know their insurance eligibility, benefits and policy/plan requirements. Please advise our staff immediately if you are unsure of your plan details and we can offer assistance.*

IF YOU ARE 65+ (or) DISABLED DO YOU HAVE; ___ MEDICARE (or) ___ A HMO MEDICARE ADVANTAGE PLAN

Secondary Insurance: BS, EXCELLUS, MVP, MEDICARE, AETNA, UNITED HEALTHCARE, CIGNA, TRICARE

OTHER: _____ ****MANY PLANS HAVE SPECIFIC PLAN COVERAGE CRITERIA THAT MUST BE FOLLOWED**

Subscriber's Name: _____ Relation: _____ Subscriber's Date of Birth: _____

Does your plan require a (please circle all that apply): co-pay co-insurance high-deductible

Does your insurance require a referral, preauthorization? ___ No ___ Yes ___ Unsure*

**It is the patient/insured's responsibility to know their insurance eligibility, benefits and policy/plan requirements. Please advise our staff immediately if you are unsure of your plan details and we can offer assistance.*

Authorization for release of Medical Information to Insurance and Assignment of Benefits to the Provider:

I hereby authorize release of medical information/records necessary to file a claim/or for other reason(s) upon their request with/to my insurance(s) and assign benefits otherwise payable to me to Kulp Physical Therapy and Massage, and/or its providers. I have received, understand, and will comply with all portions of the explanation of policy page regarding; general information, attendance, cancellation notice, treatment, billing, and insurance benefit limitations of the Kulp Physical Therapy and Massage Information packet. I understand that I must pay any/all co-payments, deductibles applied and/or balance(s) determined by my insurance to be my responsibility. I understand that if my insurance denies my claim in whole or in part, or I am uninsured at the time of service I must pay the full account balance.

Signature is an authorization you accept the terms stated above. A copy of this signature is as valid as the original.

Signature _____
Parent/guardian must sign if the patient is under 18

Date _____

Print name _____

Relation to Patient if other than self _____

Health History

Name: _____

DOB: _____

Please put an **X** or **P** by the following conditions that apply to you. Please add any comments that may clarify the condition.

Past = X and Present = P

- **Musculo-Skeletal**

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/fractured bones (current)
Strains/sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis/Osteopenia
Scoliosis
Bone or joint disease
Other: _____

- **Circulatory and Respiratory**

Dizziness
Fainting
Cold feet or hands
Cold sweats
Pressure sores
Varicose veins
Blood clots
Stroke
Heart condition
Allergies
Sinus problems
Asthma/Sinus
High blood pressure
Low blood pressure
Lymphedema
Other: _____

- **Skin**

Rashes
Allergies; Latex/Seasonal
Athlete's Foot
Warts
Acne
Other: _____

- **Digestive**

Nervous stomach
Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Diverticulitis
Irritable bowel syndrome
Crohn's Disease
Colitis
Adaptive aids
Other: _____

- **Nervous System**

Numbness/tingling
Twitching of face
Fatigue
Chronic pain
Sleep disorders
Ulcers
Paralysis
Shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's disease
Spinal cord injury
Other: _____

- **Reproductive System**

Pregnancy:
 Current Previous
PMS
Menopause

- **Other**

Hearing impaired/Hearing Aid
Visually impaired/Glasses/Contacts
Bladder infection
Diabetes
Fibromyalgia
Post/Polio Syndrome
Acquired Immune Deficiency
Syndrome
Cancer
Infectious disease (please list)

Other congenital or acquired
disabilities (please list) _____

Nut/Seed
Allergy _____
Surgeries _____
Other: _____

For clients who need mobility
assistance, please give your
height: _____ weight: _____

*List or provide a list of any
medications that you are currently
taking including aspirin and
nutritional supplements:

Additional Comments about my health & overall well being: _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.