Kulp Physical Therapy
1331 East Victor Road
Victor, NY 14564
585-742-8270

Today's Date:_____

Use Blue or Black Ink please

PATIENT INFORMATION

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)

Doctors * Your Primary Care and/or Referring provider(s) will be sent progress notes unless you indicate otherwise.

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

INSURANCE INFORMATION

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 request and 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.

Health History

Name:_____ DOB:_____

Please put an **X** or **P** by the conditions that apply to you, past **X** and present- **P**. Please add any comments that may clarify the condition.

- **Musculoskeletal**

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
Pacemaker
Allergies
Sinus problems
Asthma/Sinus
High blood pressure
Low blood pressure
Lymphedema
Other: _____

- **Skin**

Rashes
Athlete's Foot
Warts
Acne
Allergy to; Adhesives
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:
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)
_____
Disabilities (please list) _____
_____
Nut/Seed Allergy_____

Allergy to Latex YES (or) NO

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. Signature: _____ Dates(s)_____

Are you currently receiving **ANY** home health services? (Visiting Nurse, Home Health Aide, or hospice) ____no ____ yes*

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

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Kulp Physical Therapy and Massage to disclose and/or obtain my protected health information, to/from my primary and/or referring physician's office (indicated on page #1) unless/until I request otherwise. I also authorize, the following individual(s) "Other" includes persons I want the ability to make/cancel/confirm appointments or make payments on my behalf.

Spouse/Partner_____ Other_____
Parent(s)_____ Other _____

(Name) **(Relation)** **(Phone #)**

In an Emergency call: _____, _____at #_____

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 and 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 until/unless you request otherwise**

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.

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.

ACKNOWLEDGEMENT OF REVIEW/RECEIPT OF NOTICE OF PRIVACY PRACTICES AND OTHER POLICIES

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. **____ initials**

I acknowledge that I have reviewed and understand Kulp Physical Therapy's Office policies. I can have a copy for my records at any time I request. This notice describes the responsibilities of the patient/guarantor including, but not limited to; Attendance, Communication, Guidelines, Prescriptions, Direct Access, Insurance benefits/requirements/coverage/limitations, Billing and Financial policies while receiving treatment at Kulp Physical Therapy and Massage. In the event an account becomes past due, we will refer such account(s) to a collection agency for recovery, the patient/guarantor will be help fully responsible. This includes; the unpaid debt, collection agency fees, commissions, and any/all legal fees incurred as a result of collecting the debt. **____initials**

I acknowledge that I have reviewed and understand Kulp Physical Therapy's Attendance/Cancellation Policy. I can have a copy for my records at any time I request. This notice describes the responsibilities of the patient/guarantor including, but not limited to participation in my care, arriving on time for appointments, giving no less than (1) business day notice to cancel or reschedule an appointment, understanding that giving less notice puts a burden on the staff giving them limited time to try and fill the spot and how doing so may result in Kulp Physical Therapy and Massage charging a fee of $35.00-$50.00 for each offense. **____initials**

Signature is an authorization you accept any/all 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