KINETIC PHYSICAL THERAPY
t 206.632.0163 f 206.932.2353
www.kinetic-pt.com

TODAY'S DATE _____

Patient Registration

LEGAL NAME _____ **BIRTHDATE**_____
Last First M.I.
PREFERRED NAME_____ **GENDER** _____ **PRONOUNS**_____
EMAIL _____
PHONE ( )_____hm ( )_____wk ( ) _____c
ADDRESS_____
SOCIAL SECURITY # _____
DRIVER'S LICENSE#_____
PLEASE LIST ANYONE SHARING YOUR RESIDENCE WITH YOU, THEIR AGE AND RELATIONSHIP TO YOU
_____
WORK STATUS Full Time / Part time / Not employed **STUDENT** Full Time / Part Time
EMPLOYER/SCHOOL NAME_____
EMPLOYER'S ADDRESS_____

EMERGENCY CONTACT _____ **RELATIONSHIP TO PATIENT**_____
PHONE ( )_____hm ( )_____wk ( ) _____

INSURANCE INFORMATION – PLEASE PROVIDE YOUR CARDS TO COPY

IF INSURED IS NOT THE PATIENT, PLEASE COMPLETE THIS SECTION
NAME OF INSURED _____
(Subscriber Name) Last First Middle initial
BIRTHDATE_____
Sex: Male / Female
PATIENT'S RELATIONSHIP TO INSURED: **Self / Spouse / Child / Dependent**
INSURED'S ADDRESS
_____
EMPLOYER

PRIMARY INSURANCE Co. _____**ID Number** _____ **Group number**_____
SECONDARY INSURANCE Co. _____**ID Number** _____ **Group number**_____

PLEASE NOTE: we do not bill for secondary insurance plans. We require this information to ensure your provider is credentialed with your secondary insurance plan.
IS PATIENT'S CONDITION RELATED TO: Employment / Auto / Accident / Other _____
DATE OF CURRENT ILLNESS or INJURY:
MONTH _____**DAY**_____ **YEAR**_____

REFERRING PROVIDER INFORMATION (Doctor, Naturopath, Chiropractor, Etc.)

_____
name Phone# Fax#

ADDRESS _____
Street City State Zip

FOR ALL LABOR & INDUSTRIES (L&I) CLAIMS: N/A ☐

LABOR AND INDUSTRY CLAIM NUMBER:

_____

CLAIM MANAGER: _____

PHONE (w/area code) _____

FOR ALL PERSONAL INJURY PROTECTION (PIP) CLAIMS N/A ☐

NAME OF AUTO INSURANCE COMPANY:

_____

ADJUSTER/CLAIM MANAGER NAME:

_____

CLAIMS ADDRESS:

_____

Street **City** **State** **Zip**

PHONE ( ) _____

CLAIM # _____

****

FOR ALL OF OUR PATIENTS:

We thank you very much for your assistance. This completed form will provide both you and our billing department with important information regarding your physical therapy insurance benefits, and enable us to process your claim in a timely basis.

→Please note that Co-pays are collected at the time of visit.
→Reminder that we do not bill secondary insurance.

Patient's or authorized person's signature:

- **I authorize the release of any medical records or other information necessary to process this claim.**
- **I authorize payment of medical benefits to KINETIC PHYSICAL THERAPY, LLC and/or FAWN COUSSENS, MSPT.**
- **A 1% interest rate will be charged on all balances outstanding over 30 days.**
- **I am financially responsible for any balance due.**

Signed _____ **Date** _____

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CONSENT FOR CARE AND FINANCIAL AGREEMENT

I (patient or legal guardian for patient who is minor) grant permission for licensed physical therapists at Kinetic Physical Therapy to perform such examinations and therapeutic procedures as may be professionally deemed necessary or advisable for appropriate evaluation and treatment of my condition.

As permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize the release of any and all medical information to my physician(s) and other healthcare providers as may be necessary for communication regarding my care. Additional persons I would like my health information to be made accessible to are noted below.

As permitted by HIPAA, I authorize the release of any and all of my medical records to my insurance company at their request. Other release is subject to my written consent.

I understand that all treatment fees are to be paid at the time of service unless other billing arrangements are made with Kinetic Physical Therapy, LLC and/or Fawn Coussens, MSPT. We are a preferred provider with most major insurance companies. In cases where your insurance is not billed or Kinetic Physical Therapy, LLC or Fawn Coussens, MSPT is not a preferred provider, Kinetic Physical Therapy will provide, on request, a superbill receipt that you may use to submit to your insurance carrier and/or keep for your personal records.

If my insurance company (or other responsible party) rejects payment or shows that a portion is the responsibility of the patient, I agree to make full payment within 30 days of the first billing unless other arrangements are mutually agreed upon. Exception will be made in cases where Kinetic Physical Therapy, LLC or Fawn Coussens,MSPT's contract with the insurer precludes this.

If I "no-show" or cancel an appointment without providing 24 hours of notice (excluding weekends), I am responsible for paying the cancellation fee of $75 before further treatment is provided. These charges cannot be billed to insurance. Exceptions for emergent situations may be made. If I "no-show" two times, I understand that further appointments will be cancelled.

I request that all fees paid by my insurance company or other party be paid directly to Kinetic Physical Therapy or Fawn Coussens, MSPT unless I have previously paid said fees directly to Fawn Coussens.

Co-pays are due at the time of service.

I understand that, and give permission for, my therapist may take photos or videos of me throughout my treatment to enhance my rehabilitation and track my progress.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.
Signature _____ Date_____

For the best chance of reimbursement from your insurance carrier, we *suggest that you contact your insurance company prior to your first appointment to determine your physical therapy coverage and providership stipulations.*

I authorize the following persons to have access to my health information:

_____

_____

I HAVE RECEIVED, READ AND UNDERSTAND MY PRIVACY RIGHTS AND PRACTICES (HIPAA).
Signature _____ Date_____

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BILLING INFORMATION WORKSHEET

In order to fully understand physical therapy coverage under your insurance plan, we have developed this worksheet to be completed PRIOR to your first visit.
NOTE: You are responsible for obtaining this information from your insurance company.
We thank you for your assistance in this matter.

• Insurance plan name or program name: _____
• Member ID number: _____ Group number: _____
• Customer Service phone number ( )_____
• Name of customer service representative: _____
• Insurance claim address: _____
• Date eligibility began: _____
• Deductible: $_____ Co-pay: $_____ Co-insurance: %_____
• Maximum allowable benefit for physical therapy: $_____ # visits _____
• Remaining $_____# visits _____ for current year as of _____
• Does this plan require a ***referral*** from the ***primary care physician*** to KINETIC PHYSICAL THERAPY, LLC/ FAWN COUSSENS MSPT for payment of services? Yes/No
• Does this plan require a ***prescription*** from the ***primary care physician*** to FAWN COUSSENS MSPT, LLC for payment of services? Yes/No
(NOTE THAT A PRESCRIPTION AND REFERRAL ARE NOT ONE AND THE SAME).
• How often does the referral/prescription need to be updated to ensure continuous coverage? (i.e., every 2 weeks, every month, every three months, etc.) _____
• If your company is an HMO or PPO, and we are NOT an in-network provider for the plan, what is the benefit coverage for KINETIC PHYSICAL THERAPY OR FAWN COUSSENS, MSPT? (i.e., 60%, 80%,etc.)._____%

~What this information means~

- A *deductible* must be satisfied before your insurance company will pay for treatment.
- Office *co-pays* are due at the time of service.
- You will be billed for your *co-insurance* amount
- If your policy requires a *prescription* from your PCP, or other provider, you must obtain a current prescription in order for your plan to pay for PT services.
- If your policy requires a *referral* or *pre-authorization* on file, you will need to contact your referring provider's referral coordinator and ask that a current copy is sent to both the insurance company and our office.
- Please be aware that *prescriptions*, *referrals* and *pre-authorizations* have expiration dates (typically 90d) and/or set visit limits. We can assist you in tracking these once you have initiated care with Kinetic PT.
- Rehabilitation benefits may include Occupational Therapy, Speech Therapy and often Massage Therapy as well at Physical Therapy. Additionally, some physicians or Chiropractors may bill under Physical Therapy services which may deplete your plan's set limits.
- Kinetic PT is only able to track your benefits as they apply to our services.

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TODAY'S DATE _____

Patient History Questionnaire

Name:_____ **Handedness** Right / Left

Who referred you?
□ Physician □Naturopath □ARNP □Chiropractor □Yoga / Pilates / Fitness instructor
□ Claims manager □Attorney □Other _____

Chief Condition / Current Complaint
Please describe the problem(s) that bring(s) you to PT: _____
_____
_____

Describe your symptoms (please check and indicate body region or part and describe)
□Numbness_____ □Tingling_____ □Aching_____ □Sharp pain_____
□Dull pain____ □Burning_____ □Dizziness/Lightheadedness
□Loss of range of motion_____ □Weakness____ □Functional changes (eg. difficulty with stairs)_____ □Other _____

Are your symptoms related to an accident or specific injury? Y / N If yes, please describe
_____

When did your symptoms begin? _____

Did your symptoms come on gradually? Y / N

Please rate your symptoms 0-10: __/10
0= no pain; 10= worst pain imaginable

Have you ever had this problem before? Y / N If yes, please describe
_____
Did they previously get better? Y / N How? Y / N _____

What is the frequency of your symptoms?
□Constant □Daily _____x/Day □Weekly _____x/week

How are your symptoms progressing? □Improving □Worsening □Staying the same

What makes your symptoms better? □Heat □Ice □Exercise □Rest □Medication
□Change position □Walking □Other _____

What makes your symptoms worse? □Sitting □Rising from sit to stand □Standing □Walking
□Bending □Squatting □Stairs □Kneeling □Computer □Lifting
□Other _____

Please list and score 3 activities that you are UNABLE to do or have significant difficulty doing as a direct result of your symptoms.
Rate the difficulty of your activity 0-10 0= unable to perform 10= no difficulty

Activity	0	1	2	3	4	5	6	7	8	9	10
1.											
2.											
3.											

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Are you able to continue working? □Yes, full duty □Yes, Light duty □No, as of _____

Are you able to continue your usual recreation? □Yes □Limited_____

Do you have periods of time when you are completely symptom free? Y / N

Do your symptoms awaken you or disturb you at night? Y / N
If yes, how many times? _____/night What time?_____am/pm

Have you experienced any of the following with your current problem?

□Buckling	□Locking	□Giving way
□Loss of balance	□Dislocating	□Dizziness/blurred vision
□Pain with cough/sneezing	□Bowel/bladder changes	□Numbness around groin
□Lip numbness	□Unconsciousness	

What treatment have you had for this complaint? (check all that apply)

□ None	□Physical Therapy	when_____	#visits_____
□Acupuncture	□Chiropractor	□Dentist	□Physician
□Massage therapist	□OB/Gynecologist	□Orthopedist	□Occupational therapist
□Osteopath	□Pediatrician	□Podiatrist	□Neurologist/Neurosurgeon
□Rheumatologist	□Physiatrist	□Psychologist	

Social/Health Information
Do you currently smoke? Y / N Amount _____
Did you smoke in the past? Y / N When quit?_____
Do you exercise regularly? Y / N
How many times per week? _____ How long per bout? _____
Please describe your exercise _____

General Health Status
Please rate your average health: □excellent □good □fair □poor
Have you had any major changes in the recent year (i.e. new baby, death in family, job change, etc?) Y / N
please describe_____

Medical/Surgical History

□Arthritis	□Broken bones/fractures	□Osteopenia/Osteoporosis
□Blood disorder	□Circulation/vascular disorder	□Heart problems _____
□High blood pressure	□Lung problems	□Stroke
□Diabetes/High blood sugar		□Low blood sugar/hypoglycemia
□Head injury	□Depression	□Multiple sclerosis
□Muscular dystrophy	□Parkinson's disease	□Seizures/Epilepsy
□Allergies_____	□Thyroid conditions	□Developmental/growth problems
□Cancer	□Kidney Problems	□Infectious disease(HIV, TB, HepC, etc)
□Repeated infections	□Ulcer/stomach problems	□Skin disorders _____
□Sleep Apnea	□Use of CPAP	□Urinary/bowel incontinence
□Pregnancy/Delivery_____		□Autoimmune disorder_____
□Abdominal surgeries (list next pg)		□Other_____

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Please detail & date ALL surgeries you have had (orthopedic, abdominal, laparoscopic, etc).

_____

_____

_____

Within the past year, have you experienced any of the following symptoms?

□Chest pain	□Heart palpitations	□unexplained cough
□Shortness of breath	□Dizziness or blackouts	□Coordination problems
□Loss of balance	□Difficulty walking	□Weakness in arms or legs
□Joint pain/swelling	□Pain at night	□Difficulty sleeping
□Loss of appetite	□Nausea/vomiting	□Bowel problems
□Weight loss/gain	□Urinary problems	□Headaches
□Hearing changes	□Vision changes	□Numbness/tingling _____

□Other_____

Medications- check ALL *Physician prescribed* medications currently taking:

□Aspirin	□Tylenol/acetaminophen	□Anti-inflammatories
□Muscle relaxers	□Birth control pills	□ Prescription pain relievers
□Antibiotics	□Stomach ulcer medication	□ Hormone replacement therapy
□Diuretics	□Thyroid medications	□ Heart medications _____
□Antidepressants	□Seizure medications	□Asthma medications
□Insulin	□Decongestant/antihistamine	□Steroids

□Other_____

Medications- check ALL *non-prescription* medications currently taking:

□Aspirin	□Antacids (Tums, etc)	□ Advil/Aleve/Motrin/Ibuprofen
□Decongestants	□Laxatives	□ Tylenol/acetaminophen

□Herbal supplements_____

□Other_____

Other Clinical Tests and Radiology

□Angiogram	□Echocardiogram (EKG)	□Electroencephalogram (EEG)
□MRI _____	□CT scan_____	□Electromyogram (EMG)
□X-Ray _____	□Myelogram	□Bone Scan
□Blood tests	□Spinal tap	□Stress tests (eg. Bike or treadmill)
□Pulmonary function tests	□Nerve conduction tests (NCV)	

□Other_____

Anything else you would like us to know about you?

_____

_____

Thank you!!

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