Dear First Time Patient,

Thank you for your interest and appointment with Kabat & Associates Physical Therapy. We look forward to entering with you into a positive and progressive Physical Therapy experience.

Enclosed you will find the necessary paper work that must be completed at the first visit and prior to your evaluation with the Physical Therapist. Please take this opportunity to fill in the paperwork to the best of your ability. Make sure to review each document and sign. Feel free to use our website at www.k2pt.com for helpful information. When you arrive for Physical Therapy sessions (including first one), please wear comfortable clothing to be able to exercise in and to easily allow us access to your injury. It will be best to arrive 10-15 minutes before the first appointment (especially if there are any questions with paperwork). Anticipate for your appointments to be about 60 to 75 minutes unless informed otherwise.

For your appointment please bring:

- Comfortable clothing
- A pair of most commonly worn shoes (for assessment)
- Co-payment
- Insurance card(s) and proof of ID
- Prescription for Physical Therapy in addition to helpful MD, X-ray, MRI and other comparable reports if available

We look forward to meeting you and working with you towards a positive Physical Therapy experience!

Sincerely,

Kabat & Associates Physical Therapy

Kabat & Associates Physical Therapy
5161 Lone Tree Way, Antioch, Ca 94531 phone: 925-522-8000 fax 925-522-8008

Intake Form

www.k2pt.com

Patient Information *(confidential)* **Date:**_____

Name_____ Age_____DOB_____ Gender M / F

Address_____ Referring Physician (s)_____

City/State/Zip_____ Doctors Phone Number _____

Home Phone_____ Date of next Doctor visit_____

Work Phone_____ General Physician_____

Cell Phone_____ Diagnosis_____

Email Address_____ Date of Injury_____ Surgery_____

Spouse or Parent / Guardian Name_____ Is this Injury related to: personal/work/auto/other

Emergency Contact_____ Employer_____

Contact Phone_____ How did you hear about us_____

Office Policies

1. **Cancellation/No Show/Late Notice:** A $35.00 fee will be charged for the following:
   - If you do not notify us 24 hours in advance to cancel your appointment
   - If you do not show to your scheduled appointment
   - If you are more than 15 minutes late and we are unable to see you at that time or later that day.

2. **Co-Pays:** If you have a co-pay or co-insurance, the payment is due on each scheduled appointment day.

3. **Proper Clothing:** Please wear clothing that is appropriate for exercise and allows access to your injury.

4. **Cell Phones:** We require that you refrain from use of your cell phone for verbal or text communication while involved in Physical Therapy sessions and / or in the vicinity of other patients. Cell phone usage is a distraction to your treatment progression and poses a threat to other patients' privacy.

5. **Family and Friends:** If you have family and/or friends that accompany you, they must wait in the front waiting area during your session. If a unique necessity requires their immediate presence, please let the Physical Therapist know and (depending on the situation) arrangements may be made.

6. **Home Exercise Program:** We often include a progressive home exercise / symptom management program as part of your treatment. We expect compliance as this is one of the most valuable parts of the treatment program.

X_____

Signature of Patient

Consent to Treat a Minor *(Fill out only if patient is under the age of 18)*:

I / We being the parent / legal guardian of _____ a minor age of ___ do hereby consent, authorize, and request Kabat & Associates Physical Therapy Inc. to administer such treatment as deemed advisable, necessary, or requested for the above named minor. I / we agree to hold Kabat & Associates Physical Therapy Inc. free and harmless from any claims, suits, damages or complications which may result from such treatment.

X_____ _____

Signature of Parent / Legal guardian Date Staff initials Date

Notice of Privacy Practices - Consent Form:

By my Signature below, I acknowledge that I have been given the opportunity to review the ***Notice of Privacy Practices*** for Kabat & Associates Physical Therapy.

(The notice is available for viewing on the waiting room wall, on our website at www.k2pt.com, and / or for you to take / view in paper form at our front desk).

X_____

Signature of Patient

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Kabat & Associates
PHYSICAL THERAPY

Responsible Party *(for financial reasons)*

Name of subscriber for this account_____ Relationship to patient_____
If other than self please include their: Address_____
DOB_____Phone Hm_____Wk_____ Cell_____

For your convenience we offer the following methods of payment: cash, check, Credit Card (Visa, MasterCard, Discover)

Co-pay payment is due in full at the beginning of each visit

Insurance Information

Name of Primary insurance company_____
Name of Primary name on insurance policy (if different than you)_____
ID #_____ Group#_____
Claims address of insurance company_____
Providers phone number_____
In network deductible $_____ Amount Met $_____ Out of network deductible $_____ Amt Met $_____
In network Co-Pay / Co-Insurance $_____ Out of network Co-Pay / Co-Insurance $_____
Limits per calendar year _____
Does PT need an MD referral / prescription_____
*Talked to*_____*Ext*_____ *Ref / Cert #*_____
Medicare Patients: 1) How many previous Physical Therapy visits have you had during this calendar year _____
2) Have you received home health care of any kind during this current month: Yes / No

Do you have additional insurance? Y / N (If yes, please fill out the following)

Name of Secondary insurance company_____
ID #_____ Group#_____
Address of insurance company_____
In network deductible $_____ Amount Met $_____ Out of network deductible $_____ Amt Met $_____
In network Co-Pay / Co-Insurance $_____ Out of network Co-Pay / Co-Insurance $_____

Work or Auto Related? Y / N (if yes, please fill out the following)

Name of insurance company_____
Address_____
Claim #_____ Adjuster name_____
Adjuster Phone (_____)_____ Adjuster Fax (_____)_____
Nurse Case Manager_____ Phone_____

Assignment of My Benefits

I hereby instruct and direct my sbove listed insurance company to pay by check made out to:

Kabat & Associates Physical Therapy, Inc. 5161 Lone Tree Way, Antioch, Ca 94531.

If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance of said professional service charges over and above this insurance payment.

☐A photocopy of this assignment shall be considered as effective and valid as the original.

☐I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payments benefits.

☐I authorize the use of this signature on all insurance submissions.

☐I authorize Kabat & Associates Physical Therapy to deposit checks made in my name.

☐I authorize Kabat & Associates Physical Therapy to initiate a compliant to the Insurance Commissioner for any reason on my behalf.

☐I understand that I am financially responsible for all charges whether or not paid by insurance.

X_____
Signature of Policy Holder Print Name

X_____
Signature of Patient (if other than policy holder) Print Name

Office Use only: Account#_____ ICD-9_____

Health Questionnaire

www.k2pt.com

Kabat & Associates K2 PHYSICAL THERAPY

Please Fill Out Completely **Date:**_____

Name_____ **Age**_____ **DOB**_____

When did your injury / condition occur? _____, Did it begin ___Immediately or ___gradually.

How did it occur?_____

What body parts were initially painful or affected? _____

What body parts are currently painful or affected? _____

Since this condition / injury began, are your symptoms: ___Increasing ___Decreasing ___No change.

How often do you feel your symptoms?
___Occasional (10-25%) ___Intermittent (26-50%) ___Frequent (51-80%) ___Constant (90-100%)

If you have pain, please mark your pain on the scale below. "0" is no pain, "10" is worst pain ever.
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Choose what most accurately describes your symptoms.
___Symptoms are noticeable but able to perform all activities.
___Symptoms are tolerated but may cause difficulty performing some activities.
___Symptoms interfere with performance of all activities.
___Symptoms are so severe that you are unable to perform any activity.

What makes your condition <u>feel</u> worse: ___Sitting ___Standing ___Walking ___Running ___Stairs
___Kneeling ___Bending ___Twisting ___Lifting ___Writing ___Keyboarding ___Mousing
___Repetitive Hand Motion ___Coughing ___Sneezing ___Others not listed above:_____
_____

What activities with your *personal / work* lifestyle are <u>difficult</u> as a result of your symptoms / pain:
_____
_____

What makes your condition feel better: ___ Lying Down ___Sitting ___Standing ___Walking
___Stretching ___Movement ___Exercise ___Manipulation ___Medication ___ Hot / Cold
Other:_____

Sleep: ___Good ___Fair ___Poor / **Sleep Position**: ___Back ___Side ___Stomach ___Reclined

What treatment have you already received for this condition? ___None
Physical Therapy_____ Surgery_____
Are you currently receiving Home Health services? ___ Yes ___ No
Chiropractic_____ Acupuncture_____
Other_____
Diagnostic Tests: X-Ray_____ MRI_____ CTscan_____ EMG / NCV_____
Doppler Ultrasound_____ Bone Scan_____

What medications are you taking for this condition?
1._____x per day a.m./p.m. 3._____x per day a.m/p.m.
2._____x per day a.m./p.m. 4._____x per day a.m/p.m.

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General Health (Please check / explain the categories that relate to your health below):

___Good ___Asthma ___Diabetes ___Blood Pressure (High / Low) ___Cancer
___Autoimmune ___Gout ___Dizziness ___Vertigo ___Fibromyalgia ___DDD
___Osteoarthritis ___Pregnant ___Post Partum ___Depression ___Osteoporosis ___Stroke
___Rheumatoid Arthritis ___Hernia ___Pacemaker ___Headaches ___Latex Allergy ___Vision
___Shortness of Breath ___Digestive ___TMJ ___Bowel and Bladder difficulty
Heart / Respiratory_____ Dominant Hand: R / L
Previous Injuries:_____
Complete Surgery History:_____
What assistive equipment do you use:_____
Other:_____

Medications for other conditions 1._____ 2._____ 3._____
(__List provided) 4._____ 5._____ 6._____

Approximately how many glasses of water do you drink per day:___ **Caffeine** Y / N **Smoke** Y / N

Do you have a regular exercise routine? Y / N Describe:_____

Recreational activities / hobbies_____

Are you currently working? Yes / No If no, date last worked_____
Do you have any work limitations? Yes / No If yes, list limitations_____

What are your goals from Physical Therapy?_____

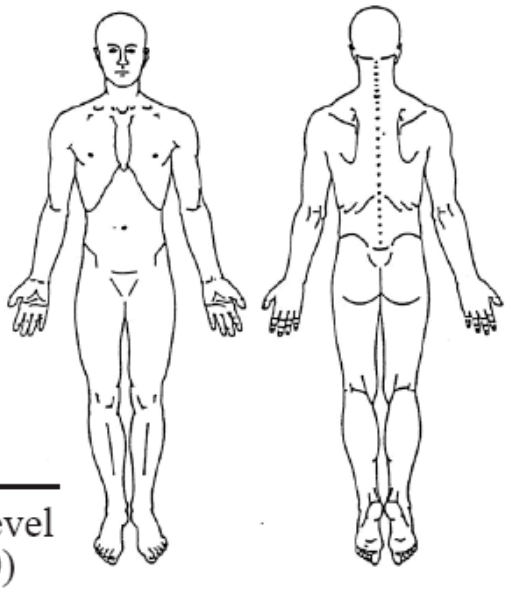
_____

_____

Pain/Symptoms

On the Body Diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning



_____
Pain Level
(0-10)

Signature:_____ Print Name:_____

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Kabat & Associates Physical Therapy, Inc.
Statement of Privacy Notice
- For reference only -
Please refer to this document when signing the "Patient Intake Form"

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (925) 522-8000. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (925) 522-8000. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature on the "**Privacy Practices Notice**" section under the "Policies" form, I provide Kabat & Associates Physical Therapy, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.