I. Personal Information

Date: ___/___/_____

Name:_____

Birthday: ___/___/_____

Gender: _____

Marital Status: **Married** **Single** **Other**

Email:_____

Address:_____

City:_____ Zip Code:_____

Phone:_____

Emergency Contact:_____

Relationship:_____

Contact Number:_____

Area Being Treated:_____

When and how did your symptoms start? _____
_____

Have you seen a physician for this condition? **Yes** **No**

What is your max pain level 0-10, 10 being the worst? 0 1 2 3 4 5 6 7 8 9 10

What is your pain level at rest 0-10, 10 being the worst? 0 1 2 3 4 5 6 7 8 9 10

What medications do you take?_____
_____
_____

Goals for Physical Therapy?_____
_____

II. LIABILITY WAIVER

I, _____ the undersigned do hereby agree to hold harmless KINETIC POTENTIAL PHYSICAL THERAPY P.C. and Golf Fitness Los Angeles from any injury, aggravation or further injury to any pre-existing condition that I may have incurred from the use of the rehabilitation and fitness equipment at KINETIC POTENTIAL PHYSICAL THERAPY, P.C. and Golf Fitness Los Angeles.

It is also understood that KINETIC POTENTIAL PHYSICAL THERAPY, P.C. and Golf Fitness Los Angeles deny any liability on its part arising from any such injury, aggravation or further injury to any pre-existing condition that I may have incurred from the use of the rehabilitation and fitness equipment at KINETIC POTENTIAL PHYSICAL THERAPY, P.C. and Golf Fitness Los Angeles.

I agree for myself, my heirs, executors, administrators and assigns to indemnify and forever hold harmless KINETIC POTENTIAL PHYSICAL THERAPY, P.C. and Golf Fitness Los Angeles against any and all manner of actions, causes of action, suits, proceedings, equity in any way associated or arising out of my use of said rehabilitation and fitness equipment, my refusal to wear protection for any activity and/or my participating in any facility programs.

I have carefully read this release completely and understand it fully. Executed at KINETIC POTENTIAL PHYSICAL THERAPY, P.C. Los Angeles, California this

_____ day of _____, 20_____.

_____ _____

(Patient name printed) (Patient Signature)

_____ _____

(Child's name printed) (guardian's signature)

_____

Witness (KPPT employee)

III. Consent and Acknowledgement

Consent:

I hereby consent to physical therapy and incidental medical services to be provided by Kinetic Potential Physical Therapy, PC. I understand that I have the option to have a second person present in the exam room for my evaluation and treatment sessions. I understand that it is my responsibility to bring this person and that Kinetic Potential Physical Therapy, PC. will not have staff available to provide this person.

Liability:

I understand and agree that Kinetic Potential Physical Therapy, PC. and/or Golf Fitness Los Angeles will not be responsible for loss or damage to my personal properties or valuables while I am on the premises of Kinetic Potential Physical Therapy, PC. and Golf Fitness Los Angeles.

Acknowledgement:

I acknowledge that I have been provided the opportunity to receive the privacy policy statement of Kinetic Potential Physical Therapy, PC. I understand I can request a paper copy of the notice at any time.

Release of Information/Notice of Privacy Policy:

I allow Kinetic Potential Physical Therapy, PC. to provide information to any third party payors or those hired by the third party payors which may be partially or wholly responsible for payment of my physical therapy bill. I allow Kinetic Potential Physical Therapy, PC. to release information to Practice Care Management Group on my behalf for billing of the said third party payors. I also allow Kinetic Potential Physical Therapy to release my information to the provider or office of provider from which I was referred.

Kinetic Potential Physical Therapy may release information to (please initial where acceptable):

_____ Family members regarding scheduling changes.
_____Voicemail regarding scheduling changes.
_____Family members regarding bills/statements.
_____Voicemail regarding bills/statements.
_____Family members regarding physical therapy/health information.
_____Voicemail regarding physical therapy/health information.

Please feel free to list any specific instructions you would like Kinetic Potential Physical Therapy, PC. to follow regarding your privacy.

_____

Print Name

_____

Signature

___/___/_____

Date

IV. Financial Responsibilities

Thank you for choosing Kinetic Potential Physical Therapy, PC. for your physical therapy needs. Please review the following policy regarding financial responsibilities for your care.

Patient Responsibility:

- All copays, coinsurance, and self pay balances are **due at the time of service unless otherwise agreed upon.**
- Insurance and Personal information provided must be accurate and up to date.
- Missed appointments or cancellations less than 24 hours in advance will be charged $100.
- A $25 fee will be charged for any returned check unpaid by your financial institution.
- Past due accounts will be charged a delinquency fee of 1.5% per month if left unpaid after 60 beyond the initial billing period. Kinetic Potential Physical Therapy, PC. reserves the right to submit to a collections agency the balance defaulted on in part or whole 90 days beyond the initial billing period.

Insurance:

We participate in several insurance plans and have verified your physical therapy benefits to the best of our ability at the time requested. It is however your responsibility to be aware of your particular insurance plan's benefits, all deductible amounts, copays, and coinsurances whether in-network or out-of-network. Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company.

[ ] Kinetic Potential Physical Therapy is in-network with your insurance company and estimated benefits are as follows:

_____Deductible _____Portion Met _____Portion Remaining

_____Copay Amount _____Coinsurance (Estimated Amount:_____)

[ ] Kinetic Potential Physical Therapy is out-of-network with your insurance company.

_____Deductible _____Portion Met _____Portion Remaining

_____Copay Amount _____Coinsurance (Estimated Amount:_____)

[ ] I will be paying out of pocket for $175 per session unless otherwise negotiated.

I have read the Financial Policy and I agree to the terms and conditions outlined within this policy. Furthermore, I agree to assign all health insurance benefits directly to Kinetic Potential Physical Therapy, PC.I recognize that the terms of this agreement are confidential between myself and Kinetic Potential Physical Therapy, PC.

Signature:_____ Date:_____/_____/_____

Printed Name:_____

V. PRACTICE POLICY & PATIENT SIGNATURE

HIPAA NOPP Consent & Acknowledgment: I have read this office's Notice of Privacy Practices or have had it explained to me. I understand this notice and have had the chance to ask questions about any matters that I do not understand.

Patient Consent:

1 . I authorize the release of any medical information necessary to process all claims, and I authorize Kinetic Potential Physical Therapy, PC to communicate with my insurance companies and other health care practitioner(s) as necessary by letter, phone, or fax.

2. If assignment is accepted, I authorize and request my insurance companies to pay directly to Kinetic Potential Physical Therapy, PC benefits otherwise payable to me. I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles, and services that are not covered or deemed "not medically necessary" by my insurance companies. Further, I understand that if an insurance claim is not paid within 45 days, I am responsible for the full amount immediately.

3. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.

4. If Kinetic Potential Physical Therapy, PC is a participating provider with my insurance companies, I understand that I am subject to the terms and conditions of my insurance policy.

Signature: _____

Date:_____/_____/_____

Print Name:_____

VI. **Direct Physical Therapy Treatment Services Disclosure**

Kinetic Potential Physical Therapy PC
10500 W Pico Blvd
Los Angeles, CA 90064
P:424-260-5778 F: 310-775-4342

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, partner, or owner 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 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 pediatric medicine from the California Board of Pediatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating 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:____/_____/_____