K2 Physical Therapy LLC
Patient Welcome Forms

Thank you for choosing K2 Physical Therapy LLC! We look forward to serving you.
Please take some time and tell us about yourself and review our policies.

Patient Name:_____ DOB:_____

Parent/Guardian/Caretaker (if applicable):_____

Home Address: _____ Sex: _____

_____ SSN: _____

Phone:_____ Email:_____

Emergency Contact Name:_____

Emergency Contact Phone:_____

Referring Physician (if applicable):_____

How Did You Hear About Us: _____

Insurance Information

Primary Insurance:_____ ID:_____

Subscriber Name:_____ Relation To Patient:_____

Subscriber DOB:_____

Secondary Insurance:_____ ID:_____

Subscriber Name:_____ Relation To Patient:_____

Subscriber DOB:_____

Legal Information (if applicable)
Attorney Name: _____

Attorney Phone Number: _____

K2 Physical Therapy LLC
Patient Consent Agreements

I consent to, or am a guardian signing for the patient named on this form to be examined and treated by K2 PHYSICAL THERAPY LLC, or a representitive therof.

Informed Consent - Initial: _____

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment directly to K2 PHYSICAL THERAPY LLC, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

Assignment of Benefits - Initial: _____

I have requested medical services from K2 PHYSICAL THERAPY LLC on behalf of myself and/or my dependents. In doing so, I agree that I become fully financially responsible for all charges incurred in the course of the treatment authorized regardless of my insurance status. I further understand that fees are due on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.
I understand that if my insurance company requires a copayment, that copayment is my responsibility and payment is due at the time of service.
I understand that if I have a high deductible insurance plan, I will be charged the estimated cost at the time of visit.
I acknowledge that my credit/debit/HAS card will be kept securely on file and authorize K2 PHYSICAL THERAPY LLC to process payments at the time of service.

Financial Policy - Initial: _____

I authorize K2 PHYSICAL THERAPY LLC to: (1) release information necessary to insurance carriers regarding my condition and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I hereby authorize K2 PHYSICAL THERAPY LLC to disclose a message pertaining to my appointments to a family member via e-mail, or a message on my home or cell phone.
I authorize K2 PHYSICAL THERAPY LLC to use my email address for appointment reminders, home exercise prescription, and educational e-mails. Emails will be sent in compliance with HIPPA standards.
I understand that I have the right to waive or revoke this authorization at any time.

Authorization to Release Information - Initial: _____

K2 Physical Therapy LLC
Patient Policies - Consent

At K2 PHYSICAL THERAPY LLC we are comitted to providing you with excellent, quality physical therapy services. We ask you make every effort to arrive on time for your appointments. Failure to provide 24 hours notice for appointment cancellations/changes may result in a $75.00 fee. This fee is regardless of insurance type and payment is the responsibility of the patient.

No Show/Cancellation Policy - Initial: _____

I understand it is common practice for K2 PHYSICAL THERAPY LLC to occasionally have photos taken that may be used for marketing purposes. I also understand that prior to any photos being taken, I will be asked for verbal consent. If verbal consent is given, then I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by K2 PHYSICAL THERAPY LLC. I understand that I may revoke this authorization at any time, but must be done in writing. K2 PHYSICAL THERAPY LLC cannot condition treatment on whether or not I sign this authorization.

Authorization For Disclosure of Patient Photographic/Video Images - Initial: _____

I have read and agree to the Informed Consent, Assignment of Benefits, Financial Policy, Authorization to Release Information, No Show/Cancellation Policy, and the Authorization For Disclosure of Patient Photographic/Video Images. A photocopy of this document is to be considered as valid as the original. In the event the patient is a minor, by signing this document, I am agreeing to the statements above.

_____ _____

Patient Name (Printed) Date

_____ _____

Patient -or- Guardian Signature Relationship to Patient

K2 Physical Therapy LLC
Patient Information Sheet

History of Present Condition

What is your chief complaint/What brings you in today? _____

_____

When did this problem begin? _____/_____/_____ Surgery? □ YES □ NO

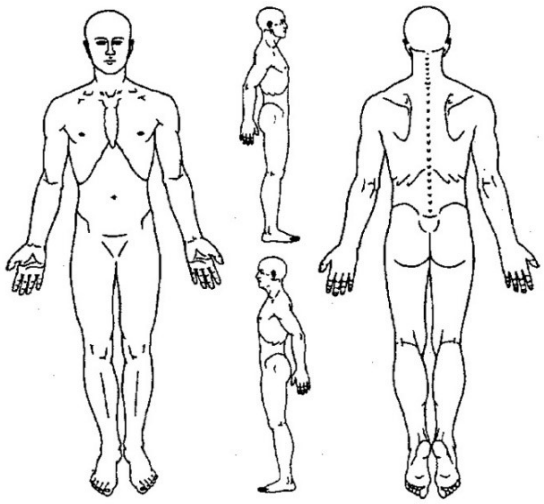
Is this problem due to a Motor Vehicle Accident? □ YES □ NO

Does this problem involve an open Work Comp Claim? □ YES □ NO

Rate the intensity of pain on a scale of 1-10 (with 0 being no pain, and 10 being the worst possible pain)

At best _____ At worst _____ On average _____

What makes the pain better? _____ Worse? _____



Please indicate where on the diagram you are feeling your symptoms.

Check any that apply:

□ Numbness	□ Dull	□ Pins & Needles
□ Burning	□ Itching	□ Stabbing
□ Throbbing	□ Sharp	□ Heaviness
□ Discomfort	□ Fire	□ Annoying

Anything else specific about your symptoms?

_____

Have you been treated by any other providers for this problem? □ YES □ NO

Who? _____

K2 Physical Therapy LLC
Patient Information Sheet

Please list ALL current medications you are taking (prescription, OTC, or vitamins) - or provide a list.

_____

_____

_____

Past Medical History

Have you had any operations or hospitalizations in the past 5 years? If yes, please explain.

_____ _____

_____ _____

Do you have, or have had any of the following:

Diabetes	□ YES	□ NO	Hypoglycemia	□ YES	□ NO
Chest Pain/Angina	□ YES	□ NO	Osteoarthritis	□ YES	□ NO
High Blood Pressure	□ YES	□ NO	Osteoporosis	□ YES	□ NO
Heart Disease	□ YES	□ NO	Hernia	□ YES	□ NO
Heart Attack	□ YES	□ NO	Seizures	□ YES	□ NO
Heart Palpatations	□ YES	□ NO	Metal Implants	□ YES	□ NO
Pacemaker	□ YES	□ NO	Dizziness/Fainting	□ YES	□ NO
Headaches	□ YES	□ NO	Fractures	□ YES	□ NO
Kidney Disease	□ YES	□ NO	Surgeries	□ YES	□ NO
History of Cancer	□ YES	□ NO	Skin Abnormalities	□ YES	□ NO
Stroke/CVA	□ YES	□ NO	Nausea/Vomiting	□ YES	□ NO
Bowel/Bladder Dysfunction	□ YES	□ NO	Tinnitus	□ YES	□ NO
Asthma	□ YES	□ NO	Rhuematic Conditions	□ YES	□ NO
Liver/Gallbladder Problems	□ YES	□ NO	Smoker?	□ YES	□ NO

Please explain any answers above:

_____

Anything else you would like us to know?

_____