Patient Information Sheet

Name_____ SS# _____ DOB_____
Address _____ City _____ State_____ZIP_____
Phone Numbers Home _____ Cell_____ Work_____
Sex (circle) M / F Marital Status(circle) single married Email address _____
Primary Physician_____ Date of Last Physical Exam _____
Previous Surgeries_____
Is this related to an accident? (circle) Yes / No If yes, which type? (circle) Automobile / Work
Date of Accident _____ Attorney Name _____

Check if you have been diagnosed with any of the following:

High Blood Pressure	____	Heart Disease	____	Pacemaker	____	Blood Clot	____
Angina/Chest pain	____	Stroke	____	Seizures	____	Incontinence	____
Asthma/Allergies	____	Dizziness	____	Diabetes	____	Headaches	____
Shortness of Breath	____	Arthritis	____	Depression	____	Osteoporosis	____
Respiratory Issues	____	Kidney Disease	____	Confusion	____	STDs	____
Unexplained weight change	____	Numbness/Tingling	____	Cancer	____	Nausea	____

I have difficulty with: (circle all that apply) exercising walking standing lifting bending driving climbing stairs self care sleep household chores hearing speech vision

Reason For Visit Today_____ Injury/Surgery date_____
Are you aware of your diagnosis? (circle) yes / no Are you aware of your rehab potential? (circle) yes / no

At Kinetic Institute Physical Therapy we pride ourselves with providing the highest quality of care to each patient. For this to be successful, we have expectations of our patients as well. Here are some guidelines to ensure that you will have an excellent experience with our office.

- Please arrive 5 minutes prior to your appointment time.
- If accompanied by a child, we ask they remain in the waiting area under supervision.
- Please silence all cell phones so as not to disturb others.
- **We have a strict cancellation policy**. Please give 24 hours notice if you are not able to make your scheduled appointment. Due to the fact we are less likely to fill an appointment slot with short notice, there will be a **$35.00 fee** for less than 6 hour notification. If you fail to contact us about an appointment cancellation, or do not show for your scheduled appointment, there will be a **$50.00 fee**.

Consent For Treatment

I hereby agree to have and give my consent to medical treatment in treating my current physical condition. I authorize release of any of my medical information needed to process my claim. Filing of my insurance is done as a courtesy to me and does not guarantee payment. I understand that I am responsible for any charges that are not covered by my insurance carrier and I am responsible for understanding the details of my insurance coverage. I understand that I am to inform this office of any changes to the insurance I gave, deductibles or coverage limitations. I authorize payment directly to Kinetic Institute regardless of participation in or out of network. Should I default on my financial responsibility, I understand that I will be presented to collections and responsible for any charges that are incurred. I have read and understand the guidelines listed above and the cancellation/no/show policy. I also acknowledge that I have seen the "Notice of Privacy Practices."

Patient/ Guardian Signature _____ Date_____