KRIZ
PHYSICAL THERAPY, P.A.

PLEASE PRINT CLEARLY

Name: _____ Today's Date: _____

Current Address: _____

Other Address: _____

Day Phone: _____ Cell Phone: _____ Email Address: _____

Soc. Sec. #:_____ Date of Birth:_____ Gender: Male ☐ Female ☐

Referring Physician: _____

In case of an Emergency, Notify: _____ Phone #: _____

Who may we thank for referring you to us? _____

Is the illness/injury for which you are being seen the result of any of the following?

Auto Accident Work Injury Other Illness/Injury being litigated None of these

Primary Health Insurance Company: _____

Secondary Health Insurance Company: _____

Driver's License # / Photo ID: _____

Authorization to Release Information and Cancellation/No Show Policy (please initial):

_____ I authorize phone messages and/or emails regarding my appointments to be left with persons or machines at the phone numbers I have provided.

_____ I authorize photos and/or videos of my home exercise program to be taken and emailed to me at the address provided above or sent via text message to the phone number I provide.

_____ I hereby understand that when **less than 24 hours' notice** is given, or later than Friday for a Monday appointment, I will be charged a **$100 cancellation/no show fee**. If you are unable to keep your appointment, we expect you to call and cancel or reschedule that appointment. You are expected to arrive for your appointment on time. If you cancel and/or no show for 3 or more appointments, you may be required to be seen by your referring physician before continuing physical therapy. Your insurance company may deny payment for services rendered if you do not follow the plan of care established by your physical therapist and physician.

Patient's Signature:_____ Date:_____

Signature of Responsible Party:_____ Relationship:_____ Date:_____

KRIZ
PHYSICAL THERAPY, P.A.

Patient History Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information. If you do not understand a question leave it blank and your therapist will assist you. Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PLEASE PRINT CLEARLY

Name:_____

I am currently: ☐ Employed ☐ Employed with restrictions ☐ On Medical Leave ☐ Not Employed

Employer:_____

Is there anyone who can assist you with doing home exercises or activities if needed? ☐ Yes ☐ No

Next Scheduled Dr. Appointment(s): Date:_____ Physician:_____

Date:_____ Physician:_____

ALLERGIES: Please list any medication(s) or materials you are allergic to: _____

_____

Have you declared the Advanced Clinical Directive of No Not Resuscitate? ☐ Yes ☐ No

General Health

1. Medical conditions you have or have had. (e.g. high blood pressure, diabetes, etc.)
   Please list: _____

2. Have you ever been diagnosed with any of the following conditions?:

Cancer	☐ Yes	☐ No	If yes, please describe what kind:		
High Blood Pressure	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Emphysema/Bronchitis	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No	Other Arthritis Condition	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No

3. Have you had any surgical or invasive procedures? ☐ Yes ☐ No If yes, please list: _____

_____

4. Uncontrolled leakage of urine? ☐ Yes ☐ No
5. Loss of bowel control? ☐ Yes ☐ No

continue on next page

KRIZ
PHYSICAL THERAPY, P.A.

Patient History Questionnaire *continued*

6. Do you smoke? ☐ Yes ☐ No Packs per day: _____
7. Do you drink alcohol? ☐ Yes ☐ No Drinks per Week:_____ Height:_____
8. Is there any chance you might be pregnant? ☐ Yes ☐ No Weight:_____
9. Are you on a special diet? ☐ Yes ☐ No
10. How much caffeinated coffee or caffeine containing beverages do you drink per day?
11. Which of the following over the counter medications have you taken in the past week?

    ☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen ☐ Aleve ☐ Decongestants

    ☐ Antihistamines ☐ Antacid ☐ Vitamins/Minerals Supplements ☐ Herbals/Remedies

    Other (please list): _____
12. Are you taking any prescription medications? ☐ Yes ☐ No

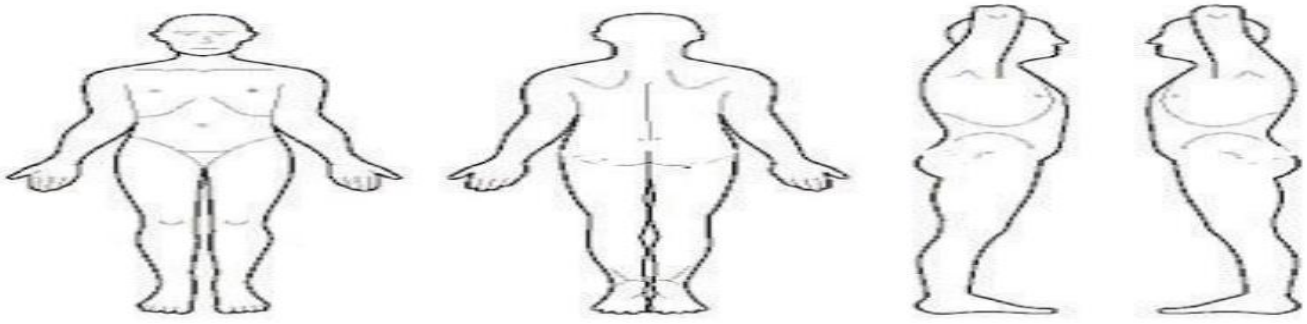
    If yes, Please list or attach separate sheet (including pills, injections, and skin patches)

13. For patients 12 years and younger, is immunization/vaccination status current? ☐ Yes ☐ No
14. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

    ☐ Diabetes ☐ Cancer ☐ Heart disease ☐ Alcoholism ☐ Stroke ☐ Kidney disease

    ☐ Depression ☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)

15. Please place an X on the areas of pain:



16. What do you WANT TO achieve from having therapy? Check all that apply.
    - Improve home activities
    - Improve mobility/walking activities decreased or eliminate pain/discomfort
    - Improve leisure/sports activities
    - Return to work: ☐ Current Job ☐ Other Job
    - Improve Self Care activities other:

Patient Signature:_____ Date: _____

Therapist Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

CONSENT FOR CARE AND TREATMENT:

I, the undersigned, do hereby agree and give my consent to Kriz Physical Therapy, P.A. to provide medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian/Responsible Party Signature: _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION:

I, authorize **Kriz Physical Therapy, P.A**. to release to my insurance company any medical information necessary to process claims and treatment that I received under their care in order to secure payment. I authorize payment of any insurance benefits for physical therapy service to be paid directly to Kriz Physical Therapy, P.A.

Patient/Guardian/Responsible Party Signature: _____Date _____

FINANCIAL POLICY/NOTIFICATION OF PATIENT RESPONSIBILITY:

Kriz Physical Therapy will bill your insurance carrier solely as a courtesy to you. If any payment is made directly to you for services billed, you recognize an obligation to promptly submit same to Kriz Physical Therapy, P.A.

It is our policy to collect your co-payments, co-insurances, and/or any unmet deductible amounts from you at the time of service. In the event that a check is returned for Non-Sufficient Funds, a $25.00 service fee will be charged to you.

We have verified your Physical Therapy benefits with your insurance company, based on the information provided by you. Please be advised that your insurance company has the disclaimer that this is a verification of benefits only, and not a guarantee of payment. Benefits/payments are determined once the claim is received. We do not accept responsibility for the accuracy of the information provided by your insurance company. We recommend that you contact your insurance company directly if you have any questions or concerns regarding your benefits.

The following is an **estimate** of the amount(s) you are responsible for and your benefits provided to us by your insurance company:

Co-Payment $_____/visit or Co-Percentage_____%/visit

Deductible Amount $_____ Deductible Amount Met $_____ Max Out of Pocket $_____

Other Benefit Information: _____

Please Note: Coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balances. Any remaining balance due will be billed to you after additional information is received from your insurance company.

Please verify that you understand your financial responsibility by signing and dating this form:

I understand and agree that if I fail to make any payments I am responsible for in a timely manner, I will be responsible for all costs of monies owed, including court cost, collection agency fees, and attorney fees.

Patient/Guardian/Responsible Party Signature: _____ Date _____

Clinic Representative: _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Kriz Physical Therapy, PA (Kriz Physical Therapy, P.A.)** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Kriz Physical Therapy, P.A.**'s personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Kriz Physical Therapy, P.A.** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that **Kriz Physical Therapy, P.A.** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Kriz Physical Therapy, P.A.** is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

☐ I DO NOT authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

☐ I DO authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Kriz Physical Therapy, P.A. and agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative | Date | Relationship to Patient

_____

Printed name of patient

Effective date April 14, 2003