***KING PHYSICAL THERAPY*** ***PATIENT INFORMATION SHEET***

| **Name:** *Last* | *First* | ***MI*** | **Sex:** | **DOB:** | **Age** |
|---|---|---|---|---|---|
| **Address:** | *City* | *State* **PA** | *Zip* | | |
| **Marital Status**: | **SS# N/A** | **E-Mail Address:** | | | |
| **Telephone:** ***(H)*** | ***(C)*** | ***(W)*** | | | |
| **If Minor, Parent / Guardian** | **How did you hear about us?** | | | | |

**INSURANCE INFORMATION**

| **Primary Insurance:** | **Secondary Insurance:** |
|---|---|
| Member ID No: | Member ID No: |
| Subscriber's Name: | Subscriber's Name: |
| Subscriber's Birth Date: | Subscriber's Birth Date: |
| Subscriber's SS No: **N/A** | Subscriber's SS No: |
| Subscriber's Employer: | Subscriber's Employer: |

**WORKER'S COMP OR AUTO CLAIM INFORMATION (*Also complete Insurance Information)***

| | |
|---|---|
| WC or Auto Insurance: | Claim No: |
| Claim Adjuster Name: | Claim Adjuster Phone No: |
| WC or Auto Ins. Address: | Date of Injury: |

**DIRECT PAYMENT REQUEST AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

"I hereby authorize King Physical Therapy to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to include Medicare benefits directly to King Physical Therapy. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof."

_____ _____

Beneficiary Signature Date

"I request the payment of authorized Medigap benefits to be made to King Physical Therapy for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to _____ any information needed to determine these benefits payable for related services.

_____ _____

Beneficiary Signature Date

***KING PHYSICAL THERAPY*** ***PAST MEDICAL HISTORY FORM***

| **NAME** | | **MI** | **DOB**: | **AGE** |
|---|---|---|---|---|

Are you presently working? Yes___ No___ Date of next physician's visit: _____ Date of injury/onset: _____

Check which apply to your symptoms:

- ☐ work related injury
- ☐ motor vehicle accident
- ☐ recurrence of previous injury
- ☐ injury related to lifting
- ☐ injury related to falling
- ☐ athletic/recreational injury
- ☐ cause unknown
- ☐ other: _____

Have you ever had these symptoms before?
Yes ___ No ___

Have you had a related surgery?
Yes___ No___

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

| | | | | | |
|---|---|---|---|---|---|
| Allergies | __ Yes __ No | Dizzy Spells | __ Yes __ No | MRSA | __ Yes __ No |
| Anemia | __ Yes __ No | Emphysema/Bronchitis | __ Yes __ No | Multiple Sclerosis | __ Yes __ No |
| Anxiety | __ Yes __ No | Fibromyalgia | __ Yes __ No | Muscular Disease | __ Yes __ No |
| Arthritis | __ Yes __ No | Fractures | __ Yes __ No | Osteoporosis | __ Yes __ No |
| Asthma | __ Yes __ No | Gallbladder Problems | __ Yes __ No | Parkinson's | __ Yes __ No |
| Autoimmune Disorder | __ Yes __ No | Headaches | __ Yes __ No | Rheumatoid Arthritis | __ Yes __ No |
| Cancer | __ Yes __ No | Hearing Impairment | __ Yes __ No | Seizures | __ Yes __ No |
| Cardiac Conditions | __ Yes __ No | Hepatitis | __ Yes __ No | Smoking | __ Yes __ No |
| Cardiac Pacemaker | __ Yes __ No | High/Low Blood Pressure | __ Yes __ No | Speech Problems | __ Yes __ No |
| Chemical Dependency | __ Yes __ No | High Cholesterol | __ Yes __ No | Stroke | __ Yes __ No |
| Circulation Problems | __ Yes __ No | HIV/AIDS | __ Yes __ No | Thyroid Disease | __ Yes __ No |
| Currently Pregnant | __ Yes __ No | Incontinence | __ Yes __ No | Tuberculosis | __ Yes __ No |
| Depression | __ Yes __ No | Kidney Problems | __ Yes __ No | Vision Problems | __ Yes __ No |
| Diabetes | __ Yes __ No | Metal Implants | __ Yes __ No | COVID-19 | __ Yes __ No |

If "Yes" to any of the above, please explain and give approximate date/describe any other conditions:

_____

_____

**Surgical History**

Body Region: _____ Surgery Type: _____ Date: _____
Body Region: _____ Surgery Type: _____ Date: _____

**Current Medications**

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Do you participate in any sports, exercise programs, or activities on a regular basis? Yes___ No___

| Patient's Signature | Date | Signature of Guardian, if Minor | Date |
|---|---|---|---|
| Therapist's Signature | | | Date |

**King Physical Therapy** **Patient Confidentiality**

| NAME: | | *MI* | DOB: |
|---|---|---|---|

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payors.

Conduct normal health care operations such as quality assessments.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that *King Physical Therapy* has the right to change its *Notice of Privacy Practices* from time to time and that I may contact *King Physical Therapy* at any time to obtain a current copy of the *Notice of Privacy Practices*.

| Signature: | Date: |
|---|---|

I _____ give permission to King Physical Therapy to discuss information pertaining to myself and my medical condition with the people listed below:

| Family Member: | Phone #: |
|---|---|
| Friend: | Phone #: |
| Answering Machine: | Phone #: |
| In Case of Emergency: | Phone #: |

<u>If patient is a minor, please indicate the following:</u>
Are minor patient's parents divorced? Yes No
If yes, do parents share joint custody? Yes No
If no, which parent has sole custody of minor? _____
May we share minor patient's health care information with the non-custodial parent? Yes No

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**<u>OFFICE USE ONLY</u>**

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

DATE: INITIALS: REASON: