

**KINECTED FUNCTIONAL MANUAL THERAPY® AND REHABILITATION**

First Name: \_\_\_\_\_ MI: \_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Emergency Contact Name (**Required**): \_\_\_\_\_Emergency Contact Phone number (**Required**): \_\_\_\_\_

Legal Guardian Name/Phone Number (if applicable): \_\_\_\_\_

Primary Care Physician Name (**Required**): \_\_\_\_\_Primary Care Physician Phone Number (**Required**): \_\_\_\_\_

Referring Physician Name/Phone Number (if applicable): \_\_\_\_\_

How did you hear about KFMT?: \_\_\_\_\_

Insurance Information (**Optional**, but recommended if submitting for out-of-network benefits):

\_\_\_\_ Check here if you are planning on submitting for out-of-network benefits from you insurance plan

Insurance Company and Plan: \_\_\_\_\_

Policy ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Name and Date of Birth: \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_



**Release of Information:**

KFMT is authorized to release all medical information needed to process applications for financial coverage for services rendered during the visits of the patient named below.

This information may be released to third party payors and others assisting KFMT in obtaining payment including billing, coding and collection agents and to its attorneys and consultants or to any employer as necessary to secure payment.

I/we further authorize KFMT to release medical records/information to the patient's primary care, referring physician, or other physicians and practitioners involved in my care.

**Insurance & Reimbursement:**

I understand that KFMT is an out-of-network practice requiring up-front payment and does not accept insurance at this time, nor does it submit or process claims with my insurance carrier. If requested, KFMT will, however, provide me with an itemized statement (a "superbill") that I may submit to my insurance company for reimbursement of the services it may cover. I understand that KFMT can not guarantee reimbursement for these services from insurance.

**Guarantee of Payment/Financial Responsibility:**

I understand that I am fully responsible for the balance due, based upon KFMT's charges which I agree are fair and reasonable.

I/we understand that any balance, is my/our responsibility. I/we agree to pay the balance within 30 days of receipt of invoice or contact Kinected to arrange a payment plan. Failure to respond as outlined above will result in the account being turned over to a collection agency. All balances in excess of 90 days are subject to a monthly finance charge of 1.5%.

I/we understand that if I/we am/are unable to attend a scheduled appointment, I am required to call to cancel the appointment 24 hours prior to said appointment; otherwise a \$60.00 fee will be incurred which is not reimbursable by insurance. If my scheduled appointment is cancelled less than 4 hours prior to treatment or I do not show up, I understand I will be charged a full fee for the cost of the treatment session.

**HIPAA Acknowledgement:**

I/we hereby acknowledge that I/we have been offered a copy of the Notice of Privacy Practices as required by HIPAA. In addition, I have been offered the KFMT Patient Rights and Responsibilities for review. These forms are also available on the KFMT website at [www.kinectedfmt.com](http://www.kinectedfmt.com) at any time in the future should you not want a paper copy.

**Direct Access:**

I/we understand that, in New York state, patients are able to be evaluated and treated by a licensed physical therapist without a physician's referral, called Direct Access. ***I/we understand that some insurance plans may still require me to consult with a physician first and acquire a prescription for Physical Therapy, in order to be reimbursed for services, and that it is the patient's responsibility to find this out prior to initiating treatment.*** I/we understand that Direct Access treatment can be rendered by a Licensed physical therapist for **10 visits** or **30 days**, whichever comes first; after one of these requirements has been reached, a physician's referral is necessary to continue treatment.



**Personal Valuables:**

KFMT and Kinected are not be liable for loss or damage to money, jewelry, documents, or articles of value while the patient is present on its premises.

**Online Communication:**

I understand that KFMT and Kinected cannot guarantee the security of email communication. E-mail sent over the Internet is not secure and caution should be used to communicate confidential and/or health information directly to KFMT. KFMT and Kinected shall not be liable for any breach of confidentiality resulting from such use of e-mail via the Internet. If I choose to communicate with KFMT and/or Kinected regarding confidential medical information, I choose to do so at my own discretion. I also understand that if I do not wish to use online communication with KFMT staff, I must verbally inform staff and provide a written statement stating this preference for KFMT records.

In addition, I understand and agree that all Home Exercises and Patient Education forms will be furnished via an online, password protected, file sharing platform. If I explicitly do not wish to receive Home Exercises via online sharing (e-mail or online platform) I must verbally inform staff and provide a written request not to have any home exercises shared with me by file sharing platform or e-mail.

**Patient Consent:**

I, the undersigned, do hereby authorize KFMT to furnish me (or the patient-minor mentioned below) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition.

I acknowledge that no guarantees or assurances have been given to me concerning the results or findings intended from the treatment or examination at KFMT. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction. This consent will cover this and *all* future visits made by me (or the patient-minor) to any Physical Therapist at KFMT., even if care is discontinued and re-started at a later date.

**Consent:**

By signing my name below, I verify that I have read and agree to the information contained in this packet and that the information I have provided is true and accurate.

\_\_\_\_\_  
**Patient's Signature** (or responsible party  
if the patient is minor or unable to sign)      **Date**

\_\_\_\_\_  
**Relationship to Patient (if applicable)**      **Date**

This is your confidential medical record to be utilized solely by your physical therapist.

\_\_\_\_\_ Initial here to authorize release of this information to other practitioners at Kinected with whom you may also elect to work (in lieu of completing a separate health form).

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Leisure activities, including exercise routines: \_\_\_\_\_

Occupation, including activities that comprise your workday: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you smoke? Yes No

Do you have a pacemaker? Yes No

Are you latex sensitive? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

FOR WOMEN: Do you currently have an Intrauterine Device (IUD) Yes No

ALLERGIES: List any medication(s) you are allergic to: \_\_\_\_\_

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> fatigue                           | <input type="checkbox"/> numbness or tingling                 | <input type="checkbox"/> constipation        |
| <input type="checkbox"/> fever/chills/sweats               | <input type="checkbox"/> muscle weakness                      | <input type="checkbox"/> diarrhea            |
| <input type="checkbox"/> nausea/vomiting                   | <input type="checkbox"/> dizziness/lightheadedness            | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain difficulty       | <input type="checkbox"/> heartburn/indigestion                | <input type="checkbox"/> fainting            |
| <input type="checkbox"/> maintaining balance while walking | <input type="checkbox"/> difficulty swallowing                | <input type="checkbox"/> cough               |
| <input type="checkbox"/> falls                             | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches           |

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> cancer                                    | <input type="checkbox"/> depression                       | <input type="checkbox"/> thyroid problems   |
| <input type="checkbox"/> heart problems                            | <input type="checkbox"/> lung problems                    | <input type="checkbox"/> diabetes           |
| <input type="checkbox"/> chest pain/angina                         | <input type="checkbox"/> tuberculosis                     | <input type="checkbox"/> osteoporosis       |
| <input type="checkbox"/> high blood pressure                       | <input type="checkbox"/> asthma                           | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems                      | <input type="checkbox"/> rheumatoid arthritis             | <input type="checkbox"/> epilepsy           |
| <input type="checkbox"/> blood clots                               | <input type="checkbox"/> other arthritic condition        | <input type="checkbox"/> kidney problems    |
| <input type="checkbox"/> stroke                                    | <input type="checkbox"/> bladder/urinary tract infection  | <input type="checkbox"/> ulcers             |
| <input type="checkbox"/> anemia                                    | <input type="checkbox"/> eye irritation/infection         | <input type="checkbox"/> liver problems     |
| <input type="checkbox"/> chemical dependency<br>(i.e., alcoholism) | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis          |

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer              | <input type="checkbox"/> diabetes   | <input type="checkbox"/> tuberculosis     |
| <input type="checkbox"/> heart problems      | <input type="checkbox"/> stroke     | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots      |

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Please list any surgeries or other conditions for which you have been hospitalized (including dates):

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1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

What date (roughly) did your present symptoms start? \_\_\_\_\_

What do you think caused your symptoms? \_\_\_\_\_

My symptoms are currently:  Getting better  Getting worse  Staying about the same

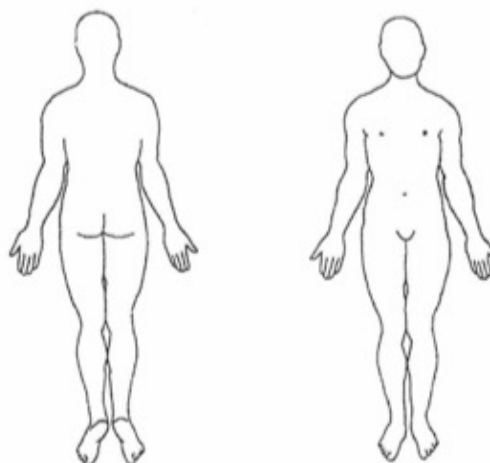
Treatment received so far for this problem (chiropractic, injections, etc.): \_\_\_\_\_  
 \_\_\_\_\_

Please list special tests performed for this problem (x-ray, MRI, labs, etc.): \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had this problem before: YES NO When: \_\_\_\_\_

**Body Chart:**

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

My symptoms currently:  Come & go  Are constant  Are constant, but change with activity

**Aggravating Factors:** Identify up to 3 important positions or activities that make your symptoms worse:

1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

**Easing Factors:** Identify up to 3 important positions or activities that make your symptoms better:

1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_



**How are you currently able to sleep at night due to your symptoms?**

No problem sleeping     Difficulty falling asleep     Awakened by pain     Sleep only w/ medication

When are your symptoms **worst**?     Morning     Afternoon     Evening     Night     After exercise

When are your symptoms the **best**?

Morning     Afternoon     Evening     Night     After exercise

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**Using the 0-10 pain scale**, with 0 being "**no pain**" and 10 being the "**worst pain imaginable**" please describe:

Your current level of pain while completing this survey: \_\_\_\_\_

The best your pain has been during the past 24 hours: \_\_\_\_\_

The worst your pain has been during the past 24 hours: \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_