KFMT
Kinected Functional Manual Therapy

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 _____

151 W 19th Street, 2nd Floor New York, NY 10011 212-463-8338 info@kinectedcenter.com

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 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)?

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

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

- ☐ cancer
- ☐ heart problems
- ☐ high blood pressure
- ☐ diabetes
- ☐ stroke
- ☐ depression
- ☐ tuberculosis
- ☐ thyroid problems
- ☐ 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):

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.): _____

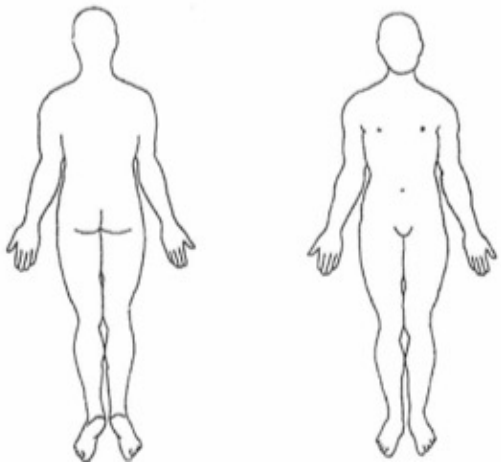
_____

Have you ever had this problem before: YES NO When: _____

Body Chart:

↓ Shooting/sharp pain
O 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

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** _____

KFMT
Kinected Functional Manual Therapy

HIPAA Notice of Privacy Practices and Disclosures

Updated January, 2017

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please Review it carefully***

We at KFMT have a legal responsibility to focus on the privacy and security of your Protected Healthcare Information (PHI). The federally-mandated program, Health Insurance Portability & Accountability Act of 1996 (HIPAA), has set standards for the disclosure and protection of individually identifiable health information and any medical records related to those individuals. This Act gives you the right to understand and control how your health information is being disclosed. In compliance with HIPAA, we are notifying you of your responsibilities and how we are required to maintain privacy of your records.

When it comes to your personal health information (PHI), you have certain rights. Although your health record is the physical property of Kinected Functional Manual Therapy and Rehabilitation (KFMT), the information belongs to you.

You have the right to the following :

1) Get an electronic or paper cop m,my of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost- based fee.

2) Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

3) Request a restriction on certain uses or disclosures

You can request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction, unless the request relates to a restriction on disclosures to your health insurer regarding health care items or services for which you have paid out-of-pocket and in full.

4) Obtain a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

5) Alternative Means of Communication

You may request that we communicate your health information by alternative means or at alternative locations. We will accommodate reasonable requests made in writing.

6) Get a copy of this Privacy Notification

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

7) Choose someone to act on behalf of you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

8) File a complaint if you feel your rights have been violated

You can complain if you feel we have violated your rights by contacting us. Any complaint must be in writing and addressed to Elliot Fishbein, KFMT Compliance Officer, Kinected Functional Manual Therapy and Rehabilitation, 151 W 19th Street, 2nd floor, New York, NY 10011. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 , calling 1- 877-696-6775, or

visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Responsibilities of KFMT with regards to your health information:

In addition to other responsibilities identified in this notice, KFMT is also required to:

1) Notify you of any Breach

Subject to certain exceptions under the law, we are required to provide notice to you of any unauthorized acquisition, access, use or disclosure of your protected health information to the extent it was not otherwise secured

2) Provide you with a Notice of Privacy Practices

We are required to provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you

3) Compliance

We are required to comply with the terms of this notice

4) Restrictions

We are required to notify you if we are unable to agree to a requested restriction on certain uses and disclosures

5) Changes to Privacy Practices

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change, we are not required to notify you, but we will have the revised notice available upon your request at KFMT's physical location. The revised notice will also be posted at our website at www.kinectedfmt.com.

For any of the above, or if you have questions about access to your medical records, please contact Elliot Fishbein PT, OCS, CFMT, FAAOMPT (our HIPAA Privacy Officer)

Uses and Disclosures of Medical Information That Do Not Require Your Authorization.

151 W 19th Street, 2nd Floor New York, NY 10011 ph: 212-463-8338 f: 212-463-8309

The following categories describe different ways that we may use and disclose medical information without your authorization. For each category of uses or disclosures we will explain what we mean, but not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information without your authorization should fall within one of the categories.

1) To treat you

We can use your health information and share it with other professionals and providers who are treating you or who may treat you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

2) To run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

3) Bill for your services (for payment purposes)

We can use and share your health information to bill and get payment, or allow you to be reimbursed from health plans or other entities. Example: We give information about you to your health insurance plan so it will reimburse you for payment for services provided.

In addition to the above, we also use and disclose your health information without your authorization as otherwise permitted by law. Examples of those uses and disclosures include the following:

1) Disclosures to business associates

There are some services that our organization may choose to utilize through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

2) Communications regarding treatment alternatives and appointment reminders

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of

151 W 19th Street, 2nd Floor New York, NY 10011 ph: 212-463-8338 f: 212-463-8309

interest to you.

3) Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or
- Domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

4) Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

5) Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

6) Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Uses and Disclosures of Medical Information for Which you may opt out

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

151 W 19th Street, 2nd Floor New York, NY 10011 ph: 212-463-8338 f: 212-463-8309

- Share information in a disaster relief situation
- Not contact you for fundraising efforts

Uses and Disclosures of Medical Information for Which Your Authorization is Required

In these cases we *never* share your health information unless you give us written permission:

- Marketing purposes (other than appointment reminders and face-to-face discussions)
- Any disclosure which constitutes a sale of your health information

For more information on your rights regarding your health information, see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

151 W 19th Street, 2nd Floor New York, NY 10011 ph: 212-463-8338 f: 212-463-8309