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

KFMT

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 payers 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.
Your contact information may be used by KFMT for business notifications and marketing, and you may opt out of marketing at any time.

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 immediately after my/our appointment, 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 after 30 days of non-payment. 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 late cancellation fee of 50% the appointment cost, with a minimum fee cost of $85, 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.

I understand that I may opt into a Flex Rate if there is financial need. KFMTs rates may change at anytime for any business reason, and flex rates may be revoked with notice given.

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/text communication. E-mail/text 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/text communication with KFMT staff, I must verbally inform staff followed by providing 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.

I waive, indemnify, exonerate, hold harmless KFMT & Kinected staff or employee of KFMT/Kinected and their assigns for any claims, demands and causes of action (including attorney's fees) arising out of or incidental injury that may occur while on the premises not related to negligence on the part of KFMT & Kinected. I hereby acknowledge that I possess adequate medical and hospitalization insurance coverage in case of injury. I further acknowledge that I have fully informed the Physical Therapy staff of all pertinent health conditions so that a Physical Therapy treatment plan and exercise prescription plan can be tailored to my individual medical conditions to minimize any risks associated with treatment.

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. I agree and consent to any future updates to the policies within this form.

_____ _____

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. _____

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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.): _____

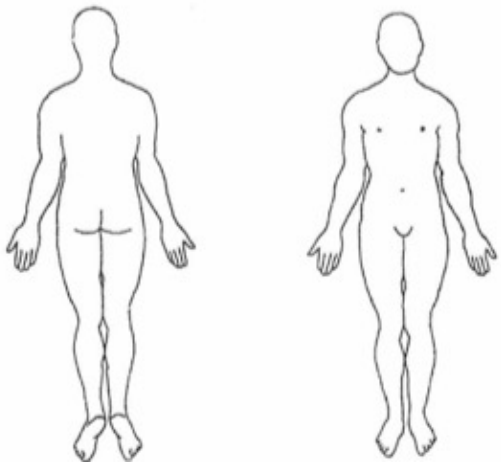
_____

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. _____

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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** _____