EVALUATION QUESTIONNAIRE

KOH Physical Therapy Lab

Patient Name _____ **Today's Date** _____

◯ New Patient ◯ Returning Patient ◯ Auto Collision – Attorney Name (*if applicable*)? _____ ◯ Work Injury

Current Health: ◯ Excellent ◯ Very Good ◯ Fair ◯ Poor **Referring Physician or Surgeon:** _____

Current Occupation: _____ **Date of Injury:** _____

Primary Concern: _____

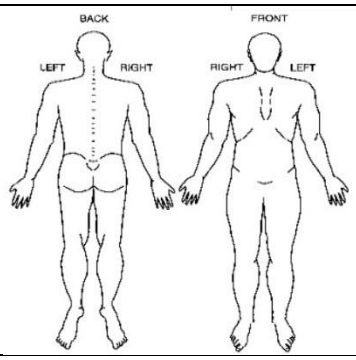
How did this injury occur: _____

_____

_____

Have you received any treatment for ***this*** injury already? ◯ Yes ◯ No If yes, please specify: _____

If **Post-Op/Surgery** Date**:** _____ Procedure/Type: _____

Rate **Pain Scale** from 1 (*least pain*) to 10 (*severe pain*) **Worst** _____/**10** **Current** _____/**10** **Best** _____/**10**	Is the pain **constant** or **intermittent**? *Please describe:* _____ _____ Is it **radiating**? *If Yes, describe*: _____ _____ _____ _____	
Describe the pain or sensation you are experiencing: □ Aching □ Sharp □ Shooting □ Throbbing □ Burning □ Stiffness □ Dull □ Swelling □ Numbness □ Tingling □ Cramps □ Other _____		**Mark on the diagrams where your symptoms are present**
Aggravating factors: □ Sitting □ Standing □ Walking □ Bending □ Lying down □ Twisting □ Other:_____		**Relieving factors:** □ Sitting □ Standing □ Rest □ Lying down □ Heat □ Ice □ Other:_____

Place circle to indicate if you have had any of the following: If you have circled any of the above, please provide each date of occurrence:

Alzheimer's	Diabetes Type I	High blood pressure	Obesity
Cardiovascular disease	Diabetes Type II	History of Cancer	Osteoarthritis
Cauda Equina Syndrome	Fibromyalgia	Huntington's	Parkinson's
Cerebral vascular accident	Fracture/Suspected Fracture	Immunosuppression	Rheumatoid Arthritis
Current Infection	Muscular Dystrophy	Lupus	Traumatic Brain Injury
Other_____	Other_____	Other_____	Other_____

Health History

Allergies: _____ **Medication:** (prescription and non-prescription): _____	**List other conditions you are currently seeing primary physician for:** _____ **Are you pregnant**? ◯ Yes ◯ No Due Date: _____
Surgical History *(If more, please use the back of this page):* Type**:** _____ Date: _____ Type**:** _____ Date: _____	**Diagnostic Imaging/Tests** *(X-ray, MRI, bone scan, blood tests…)* Type**:** _____ Date: _____ Type**:** _____ Date: _____

List 3 of your worst injuries / accidents and approximately when they each occurred

Ex. Falls, strains, dislocations, surgeries, head injuries

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

KOH PHYSICAL THERAPY LAB

PATIENT INFORMATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Name:** **Title:**	❑ Male ❑ Female
Is this your legal name? ❑ Yes ❑ No If not: _____	Social Security No:	Marital status:	**Birth date**: ____ / ____ / _____

Street Address: City: State: ZIP Code:

Indicate Preferred form of Communication below

❑ Email:	❑ Cell: ( )	❑ Home: ( )	❑ Work: ( )

Occupation:	Employer:
Physician/Surgeon Name:	**Physician Phone:**

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Google

❑ CORP_____ ❑ Friend _____ ❑ Employee_____ ❑ Insurance_____ ❑ Law Office_____

❑ Location ❑ Online Search ❑ Returning Patient ❑ Yelp ❑ Other _____

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

			( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ AETNA ❑ ANTHEM BC ❑ BLUE SHIELD ❑ BCBS ❑ CIGNA ❑ MEDICARE ❑ UHC ❑ SELF PAY ❑ LIEN ❑ WORK COMP ❑ Other _____

Subscriber's name:	Subscriber's S.S. no.:	**Birth date:** / /	Policy no.:	Group no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Best phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize KOH Physical Therapy Lab and/or insurance company to release any information required to process my claims. I will notify you of any changes in my status or the above information.

_____ _____

Patient Signature *(If minor, responsible party)* ***Date***

OFFICE & FINANCIAL POLICY

KNOW YOUR INSURANCE BENEFITS

CONSENT TO TREATMENT I hereby consent to the therapeutic procedures outlined and to be performed by KOH Physical Therapy Lab (KOHPT) and their associates. I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain. I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as: heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and bladder training. I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time. I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

NONDISCRIMINATION NOTICE KOHPT complies with applicable State and Federal civil rights laws and does not discriminate, or exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

COVID-19 WAIVER OF LIABILITY & INFORMED CONSENT Risks of Opting for In-Person Services: I understand that by coming to the clinic, in-person, I am assuming the risk of exposure to the coronavirus (or other public health risk). I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.

NOTICE OF PRIVACY PRACTICES This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this policy carefully. ***For more detailed information, please request a printout.***

Understand your health record and information: When receiving physical therapy services from KOHPT, a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation, and your treatment plan. It also contains daily treatment notes and progress notes.

Our pledge regarding medical information: We understand that your medical information is personal and private. We are committed to protecting your information. Medical records are only disclosed in a limited amount of circumstances which may be regarding; treatment, payment, review for quality of care, federal, state, or local law, and lawsuits/disputes. If for any reason, you would like a copy of your entire record, please make your request in writing. For your protection, please have a proper ID with you if picking up records in the office.

ELECTRONIC COMMUNICATION CONSENT I consent that KOHPT can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of online communications, provided that these communications comply with privacy regulations.

APPOINTMENT REMINDERS, RESCHEDULES AND CANCELLATIONS I understand that KOHPT can reach me any time to remind me of my appointments or let me know in case of any change about my appointments. And I also understand that KOHPT can employ and use a third-party automated system to reach out to me for the purpose of appointments.

PATIENTS WITHOUT A PRESCRIPTION Per the 'Direct Access' laws, since you don't have a prescription, we are legally required to advise you of the following. "You are receiving direct physical therapy treatment services and may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician, surgeon, or podiatrist."

MEDICARE PATIENTS Please be aware that you must have a new referral from your doctor in your file at our office every 30 days. Failure to obtain a referral will result in a denial of payment from Medicare. Your therapist will work with you and your doctor to obtain additional referrals. It is your responsibility to be aware of your personal insurance and/or **Medicare** requirements and benefits (including Physical Therapy) and to schedule accordingly. As a courtesy to you, we will bill your insurance for you. Should your insurance deny payment for any reason, you will be required to pay for anything not covered by your insurance.

CONTACT INFORMATION CHANGE I accept that I am responsible for notifying the Company when my contact information(s) change. I understand that I can opt-out at any time to receive communication via text or email.

IN SIGNING, I CONSENT TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THAT I FULLY AGREE TO ALL STATEMENTS LISTED.

_____	_____	_____
Print Name	**Signature (If minor, responsible party)**	**Date**

OFFICE & FINANCIAL POLICY

KNOW YOUR INSURANCE BENEFITS

KNOW YOUR INSURANCE BENEFITS This is an agreement between KOHPT and the Patient/Responsible Party signed on this form. By executing this agreement, you are responsible for all medical bills and other charges that result from services rendered by KOH PT, deductible and co-payments are due at time services are rendered. If not paid by the following visit, a fee will be assessed. No EXCEPTIONS. It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. As a courtesy, in addition to filing your claim, we will initially ask for your ***estimated*** *co-payment*. This is only an estimate based upon the information available to us. Once your carrier has paid the claim, any remaining balance is your responsibility**. Remember benefits quoted are not a guarantee of payment.**

ASSIGNMENT OF BENEFITS I hereby instruct and assign my insurance carrier to KOH PT for the professional/medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy. Medical records will be accessible to all therapists of KOHPT.

FINANCIAL POLICY KOHPT is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. All insurance companies are not the same in what they consider to be usual and customary fees. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We recommend that you read over your policy and contact your carrier if you have any questions regarding your coverage.

CONCIERGE SERVICES All concierge services and packages are non-refundable and non-transferable, and cannot be paused or extended, whether you are on a monthly or annual membership/package. Please note that these services are not covered by your insurance carrier, and no exceptions can be made. Concierge packages renew on the anniversary date, not the calendar date. Please note that all monthly and annual concierge packages are set to renew automatically, and your account will be charged accordingly unless we receive your cancellation request at least 7 days prior to the renewal date.

MEDIA WAIVER RELEASE: AUDIO, PHOTO, & VIDEO RELEASE I hereby give my consent to KOHPT the absolute and unrestricted right and permission to take my photo, audio, and video, to reproduce, distribute and display my image, likeness, name and any other identifying characteristics, for all business, education, and marketing purposes, including but not limited to advancing KOHPT services and programs. I expressly release KOHPT from any and all claims whatsoever in connection with the use and reproduction of my image, voice, likeness, name or any other identifying characteristics in the above mentioned materials. I understand that there is no compensation for the use of the audio, photos, and/or videos of me. Unless otherwise noted the form will be valid for the lifetime of its existence. I understand that I may opt-out at any time and need to request in writing.**____YES (Consent) ____NO(Decline)**

DENIAL, DELAY OR NEGLIGENCE KOHPT is not responsible if your insurance carrier denies, delays, or is negligent with its estimated co-payments. When delayed, we will extend the reimbursement period up to thirty (30) days from date of service. This time period will not be extended to patients who provide us with the incorrect insurance information, fail to keep the information current or fail to fill out the necessary forms which their insurance carrier may request in a timely manner. If your insurance carrier postpones payment for more than 90 days, we ask that you make the remaining payment while we work together to get the insurance carrier to pay the obligated amount. Services are due and payable at the time they are rendered unless other arrangements are made in advance. A 10% finance charge will apply on accounts 60 days past due. If the account becomes past due, we will take necessary steps in contacting you to collect this debt. If these attempts do not generate a response from you, your account could be subject to the following fees: Finance Charges (currently 10%), In House Collection Fees, Collection Agency fees and any Attorney fees. If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable on or before the due date specified on the statement and is past due if not paid on or before that date. We do charge interest (10%) on all past due accounts; interest will begin accruing once the account becomes 60 days past due. **_____ Initial**

ARBITRATION PROVISION Any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Orange County, California, before one arbitrator. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. Judgment on the Award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. Allocation of Fees and Costs: The arbitrator may, in the Award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.

BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE RELATING TO THIS AGREEMENT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

_____	_____	_____
Print Name	**Signature (If minor, responsible party)**	**Date**

OFFICE & FINANCIAL POLICY

KNOW YOUR INSURANCE BENEFITS

APPOINTMENT POLICY It has always been our policy here at KOH Physical Therapy, Inc. to give our patients the benefit of the doubt when they forget to show up for an appointment or cancel an appointment with less than 24 hours-notice. There may be a charge for a missed appointment or cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally. Even if it is a last minute cancellation, we greatly appreciate you notifying us so we can attempt to schedule our waiting list patients into your space.

In an instance of a cancellation without 24 hours-notice, or no-show to a scheduled appointment, we reserve the right to charge a $ 80 fee. Subject to change without notice.

Failure to provide credit card number on file will result in a standard cash rate charge for any subsequent Cancellation/ No Show Agreement infractions. No shows are to be paid by the following session or within one week of the incident, if not paid at that time they will be invoiced with a processing fee. In addition, 3 "no-shows" (missed appointments without prior or any notification) OR cancellations less than 24 hours in advance combined may result in the loss of your physical therapy benefits. We are obliged to notify your referring physician about attendance or compliance problems and your physician may decide to discontinue your course of therapy. **This charge will not be covered by insurance, but will have to be paid by you personally.**

We reserve the right to cancel all future appointments and withhold scheduling future appointments if:
1)The first and second penalty fees are not paid within a week of the offense,
2) Offenses including and after the third offense are not paid by the next appointment or within a week, whichever occurs first.

If you decide not to attend your appointment on the same day due to a Physical Therapist preference, this will be considered a no-show. Your commitment to attending your appointments, being punctual, and following your home exercise program is crucial for us to help you recover from your injuries. We guarantee the time and day of your scheduled appointment. We are happy to provide a print out of your future appointments. **Appointment text and email are only a courtesy reminder.** You are fully responsible for all scheduled appointments. Thank you! _____ **Initial**

AGREEMENT FOR CREDIT CARD TRANSACTIONS It is our policy to obtain credit card information. We will automatically charge your credit card on file for any outstanding balance (any outstanding balances (including, but not limited to: co-pays, coinsurance, deductibles or late cancellation) charges during each scheduled appointment. Your payment each visit is an estimate of payment, according to your insurance carrier. For confirmation of claims, please refer to your Explanation of Benefits according to your insurance carrier. If there is ever any overpayment, we will issue you a refund for the difference. If you wish to update your credit card information, please let us know.

If you require a receipt for your payments, please ask each time, and we will be happy to provide one. Please be assured that your credit card information is protected according to our high standards and in compliance with applicable laws. We store it in our encrypted, HIPAA compliant file to ensure maximum security.

As the authorized personnel listed below, I hereby authorize KOH Physical Therapy, Inc. to keep my credit card information on file, which includes the account number, CV Code, expiration date, and billing zip code associated with the credit card. I understand that I am required to provide my credit card information at the time of service. _____ **Initial**

AGREEMENT FOR CREDIT CARD TRANSACTIONS In order to make the payment process more convenient for everyone, we require that you sign below indicating your understanding that we will automatically charge your credit card on file for any outstanding balances (including, but not limited to: co-pays, coinsurance, deductibles or late cancellation) charges during each scheduled appointment.Your credit card information is very well protected according to our own very high standards and in accordance with the applicable laws within our encrypted, HIPAA compliant file. KOH Physical Therapy, Inc. will not disclose any of your credit card information to anyone. If you would like a receipt, we'd be more than happy to provide one for you. Just ask at the front desk each time. I, the authorized personnel listed below, approve KOH Physical Therapy, Inc. to have my credit card information on file which entails the account number, CV Code, expiration date, and the billing zip code that is associated with the credit card.

CC # _____ Credit Card or HSA

Security Code___ ___ ___ ___ Expiration Date ___ ___/___ ___ Billing Zip Code _____

I approve KOH Physical Therapy, Inc. to charge my credit card on file regarding any payments that I owe which consist and are not limited to invoices, physical therapy treatment sessions, and any balances that I may have. I have read and understand the above agreement.

_____ _____ _____

Print Name **Signature (If minor, responsible party)** **Date**