KOH PHYSICAL THERAPY, Inc. ~ INITIAL EVALUATION QUESTIONNAIRE

Patient Name_____ Date_____Referring Physician_____ Date of Injury_____

◯ New Patient ◯ Auto Collision Do you have a lawyer? _____ ◯ Work Injury ◯ Consult

Chief Complaint _____

List primary concerns in order greatest to least: 1._____2._____

3._____4._____

Safety Precautions _____

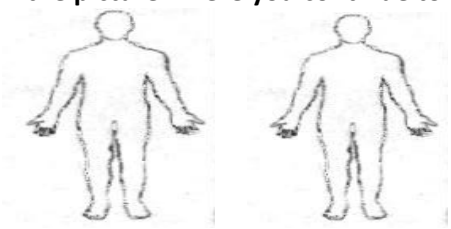
Current Health ◯ Excellent ◯ Very Good ◯ Fair ◯ Poor

Use blank line below as "timeline," describe progression & Plot/mark/indicate the events of current injury in your own history. Indicate any important dates/events correlated to the progression of symptoms to the right in order of chronicity. Include dates of previous injuries correlated to your current pain, hospital visits, imaging, surgeries & all.

USE THIS EXAMPLE TO GUIDE YOU

1st ankle sprain	2nd ankle sprain	PT	3rd ankle injury	MRI	Surgery	Current
4/4/11	12/18/11	1/1/12-3/16/12	6/10/14	7/2/14		

Mark on the picture where you continue to have pain, numbness, or tingling.



Front Back

X Pain
+ Numbness/Tingling
B Burn
Aching/Dull

Rate **Pain Scale** from
1 (least pain) to 10 (severe pain)

Pain Today _____/10
Worst _____/10
Best _____/10

Is the pain **constant** or **intermittent**?

Medication: (prescription and non-prescription):
_____

Does it interfere with your: ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation ◯ Other:_____

Aggravating factors: ◯ Sitting ◯ Standing ◯ Walking ◯ Bending ◯ Lying down ◯ Twisting
◯ Other:_____

Relieving Activities: ◯ Sitting ◯ Standing ◯ Walking ◯ Bending ◯ Rest ◯ Ice
◯ Other:_____

Health History

Allergies:
_____
_____
_____

List other conditions you are currently seeing primary physician for:
_____
_____

Are you pregnant? ◯ Yes ◯ No Due Date: _____

Place circle to indicate if you have had any of the following

Abdominal/inguinal hernia Implanted stimulators	Burns Hematoma Hypersensitivity Kidney dysfunction Osteomyelitis Myositis ossificans Thromboplebitis Unhealed fractures	Diabetes Growth plates (children under 18) Cataracts Thyroid gland Varicose Veins	Acute Hernia Aneurysm Connective tissue disease Fracture Malignancy Severe rheumatoid arthritis Spondylolisthesis	Cancer Cancerous lesion Epilepsy Pregnancy Pacemaker
Open wound				Acute thrombosis condition
Heart disease Hypertension Cardiovascular disease				Osteoporosis
AIDS/HIV Alcoholism Allergy Shots Arthritis Anemia Anorexia Appendicitis Asthma Bleeding Disorders Breast Lump	Bronchitis Bulimia Chemical Dependency Chicken Pox Emphysema Glaucoma Goiter Gonorrhea Gout Migraine/Headaches	Hepatitis Herpes High Cholesterol Liver Disease Measles Miscarriage Kidney Disease Mumps Mononucleosis	Pinched Nerve Pneumonia Multiple Sclerosis Polio Prostate Problem Prosthesis Parkinson's Disease Psychiatric Care Scarlet Fever Stroke	Tonsillitis Tuberculosis Tumors, Growths Typhoid Fever Rheumatoid Arthritis Ulcers Vaginal Infection Rheumatic Fever Venereal Disease Whooping Cough

If you have circled any of the above, please provide each date of occurrence:

KOH
PHYSICAL THERAPY LAB

PATIENT INFORMATION FORM

(Please Print Clearly)

Last Name_____ First Name _____ Middle Initial _____ Male Female

Date of Birth _____ Social Security #_____ Marital Status _____

Address _____City _____State: _____ Zip Code _____

Preference of Communication Phone Text (carrier_____) May we text you? Y N Email

Number in order of preference

☐ Cell Phone _____ ☐ Home Phone _____ ☐ Work Phone _____

Email Address _____ May we email you? ☐ Y ☐ N

Employer Name _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Spouse's Name _____ Phone _____

(Emergency Contact)

Emergency Contact (not living w you) _____ Phone _____

Referring Physician_____

MD Phone _____ MD Fax _____

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY INFORMATION (if other than patient – required if patient is a minor)

Responsible Party's Last Name_____ First Name _____ Male Female

Date of Birth _____ Social Security #_____ Marital Status _____

Address _____City _____State: _____ Zip Code _____

Email Address _____

INSURANCE INFORMATION (please provide Insurance Card(s) to front desk)

Primary Insurance _____ ID/Member No. _____

Group No. _____ Date of Birth of Insured _____

Insured's Full Name (if different from patient)_____ Relationship to Insured _____

Secondary Insurance _____ ID/Member No. _____

I understand and agree that, regardless of my insurance status, I **am ultimately responsible for the balance of my account for any professional services rendered.** I have read all the information of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature (If minor, responsible party) Date

OFFICE & FINANCIAL POLICY

KNOW YOUR INSURANCE BENEFITS

This is an agreement between KOH Physical Therapy, Inc. (KOH PT) 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 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.**

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 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.

_____
Initial

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 KOH PT.

_____
Initial

CONSENT TO TREATMENT I hereby consent to the therapeutic procedures outlined and to be performed by 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. **Initial**

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. I hereby acknowledge that I have read a copy of this practice's Notice of Privacy Practices.

_____
Initial

USUAL AND CUSTOMARY RATES KOH PT 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.

DENIAL, DELAY OR NEGLIGENCE KOH PT 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.

PAST DUE ACCOUNTS 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 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.

MONTHLY STATEMENT: 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.

In signing this agreement, I consent to all of the terms and conditions contained herein and the agreement will be in full effect.

_____ _____ _____

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

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.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

_____
Initial

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 $ 50 fee.

After the 1st offense a credit card number will be requested in the event that we need to charge you. 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, and/or Offenses including and after the third offense are not paid by the next appointment or within a week, whichever occurs first.

We guarantee the time and day of your scheduled appointment, but there could be changes to your booked Physical Therapist at times. This will not interrupt your treatment plan. If you miss an appointment due to change in PT, this is considered a non-24 cancel.

The main reason for this policy is that missed appointments create a hardship on our office and the continuity of your care and other patients. We have patients on our waiting list who are in need of a treatment or evaluation, and they cannot always come in with less than 24 hours-notice. Your commitment to attending your appointments, being there on time, and doing your home exercise program is critical for us to help you heal your injuries. **Please call 949-540-5641, during our office hours MON-FRI 9am-7pm, SAT 9:30am-1:30pm**.

Our office DOES NOT make reminder phone calls for your appointments. We are happy to provide a print out of your future appointments. Thank you!

I understand and agree with the above policy.

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