MODERN
PHYSICAL THERAPY

For Your First Appointment…

1. Bring a photo ID

2. Bring all current insurance cards

3. Bring referral from your physician for physical therapy

4. Bring current list of medications

5. Please wear comfortable clothing

6. Please check in at the front desk when you arrive

7. Please tell us before you follow up with your doctor so the most current treatment notes can be sent prior to your appointment

How Did You Hear About Us?

(check all that apply)

- ☐ Physician
- ☐ Family
- ☐ Friend
- ☐ Treated Here Before
- ☐ Facebook/Twitter
- ☐ Website
- ☐ Noticed Clinic from Road
- ☐ Close to Home
- ☐ Yellow Pages
- ☐ Health Insurance
- ☐ Google/Internet
- ☐ Other: _____

Patient Information Form

Patient information *

Last Name_____ First Name_____ MI_____

Address_____ Apt_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Date of Birth_____ SSN_____-_____-_____ Gender_____ Marital Status_____

Email_____

Employer

Name_____ Phone_____

Address_____

City_____ State_____ Zip_____

Emergency Contact *

Last Name_____ First Name_____ MI_____

Relationship_____ Home Phone_____ Cell Phone_____

Problem *

Major Complaint_____ When did it start_____

Motor Vehicle Accident Yes___ No___ Date of Accident_____ State Occurred_____

Open Auto Claim Yes _____ No_____ Claim # _____

Work Place Injury Yes _____ No_____ Date of Injury_____

Open Work Comp Claim Yes _____ No_____ Claim # _____

Referring Physician *

Name_____ Phone_____

Primary Care Physician *

Name_____ Phone_____

Primary Insurance

Insurance_____ ID _____

Subscriber Name_____ Date of Birth_____

Secondary Insurance

Insurance_____ ID _____

Subscriber Name_____ Date of Birth_____

Tertiary Insurance

Insurance_____ ID _____

Subscriber Name_____ Date of Birth_____

Disputes regarding benefits are between the patient and the insurance company. Notification of changes to insurance is the responsibility of the patient. All charges are ultimately the responsibility of the patient.

My representative or I, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and/or physical therapist.

Signature*:_____ Date*: _____

FINANCIAL POLICY

Thank you for choosing **Modern Physical Therapy** as your outpatient physical therapy provider. In order for you to fully benefit from our services, we would like you to become familiar with our philosophy and treatment approach. Take special note that we believe in a team approach to care. Our team involves the referring physician, us and **you**.

Philosophy of Care

- Our goal is to fully assess you and your condition through hands on research based approach. We will discuss our findings with you and together we will develop a comprehensive treatment strategy that will meet your goals. We provide compassionate yet effective treatment.
- Another goal is to empower you with a full knowledge and understanding of your condition. We believe in a free exchange of ideas and value your questions and thoughts.
- We make an effort to create a relaxed, customer oriented, and fun environment. Each day is a fantastic, fulfilled and feel good therapy day!

Appointments and Attendance

- Please arrive on time for your appointments. If you are more than 15 minutes late, your appointment **may** have to be rescheduled depending on your therapists' schedule. *Please be mindful that arriving late does not only affect your therapy but the therapy session of the person scheduled after you.*
- For treatment to be effective and covered by insurance, it is important for you to be treated consistently. If you are unable to attend an appointment, please call us **at least 24 hours** in advance to reschedule. This will allow us to give your appointment to another patient. There will be a **$25.00** service charge for any No Show appointment, or if cancellation occurs with less than 24 hour notice.
- Missing more than 2 scheduled appointments without advance notice may result in scheduling your appointments on a day-to-day basis or cancellation of future scheduled appointments.
- In order to fully benefit from therapy, it is important to attend therapy sessions consistently and perform your home program as prescribed by your therapist.
- If you feel that therapy is not meeting your needs, please bring it to our attention immediately. We will be happy to modify your program to ensure a successful recovery.

Follow-up visits with your physician

- We periodically assess your progress and send reports to your physician. Please advise us of all upcoming appointments with your physician.

Insurance

- As a courtesy, by the end of your initial visit, our front office staff will contact your insurance company to verify therapy eligibility and benefits. You are responsible for paying deductible and co-pays/co-insurances at the time of your visits.
- If you have accrued a balance of over **$100.00**, some form of payment is due at the time of service. If you are having difficulty with this payment, please talk with the office Manager regarding this matter **before** you decide to cancel appointments. Unpaid balances over **60** days will be charged a **$15.00** late fee. Returned checks will be subject to **$30.00** collection charge.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Modern Physical Therapy the medical benefits I am entitled from my insurance company and/or Medicare.

I hereby acknowledge and agree to the Financial Policy above. I will adhere to the cancellation and no show policy.

_____ _____

Patient's Signature * **(Or Authorized Signature)** **Date** *

_____ _____

Printed Name of Patient **Relationship to patient**

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 IT CAREFULLY.

Uses and Disclosures

Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations Your health information may be used as necessary to support the day-to-day activities and management of **the medical practice for Modern Physical Therapy.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Modern Physical Therapy Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice

.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Modern Physical Therapy
335 NW Barry Road
Kansas City, MO 64155

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name of the person you can contact for further information concerning our privacy practices is:

Office Manager
Lisa Aulner

I have received or been offered and declined a copy of Modern Physical Therapy's Privacy Practices. I have had the opportunity to have any questions answered regarding the privacy practices of the clinic.

_____ _____

Patient's Signature * **(Or Authorized Signature)** **Date** *

_____ _____

Printed Name of Patient **Relationship to patient if not patient**

335 NW Barry Road
Kansas City, MO 64155
816 468-5278 Tel
816 285-5278 Fax

Emergency Contact Information

I, _____, give my permission to Modern Physical Therapy to release the following information to the individuals listed below. **Even if you choose to leave this form blank, please sign and date at the bottom.**

- Date and Time of appointments
- Account information
- Insurance information
- Medical records

1)_____ _____
Name Relationship to Patient

_____
Phone Number

2)_____ _____
Name Relationship to Patient

_____
Phone Number

3)_____ _____
Name Relationship to Patient

_____
Phone Number

_____ _____
Signature * Date *

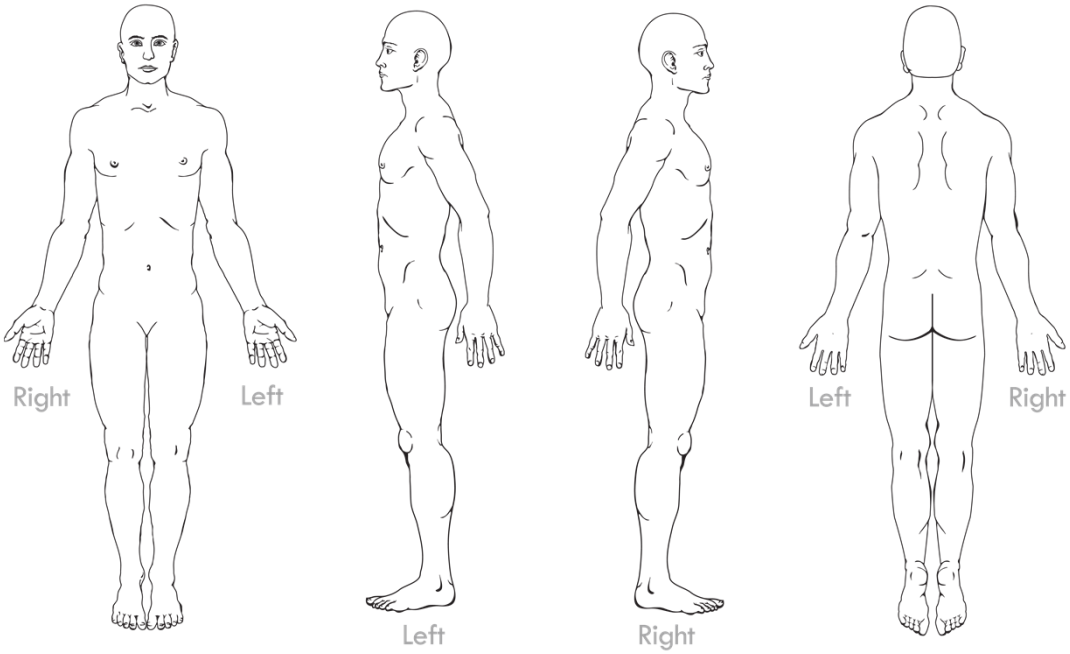
Updated_____ Date_____

Updated_____ Date_____

MODERN PHYSICAL THERAPY

Name: _____ Date: _____

Please fill in your area(s) of discomfort / symptoms, drawing as specific as you can.



YOUR PAIN: (Please indicate your level of pain by circling a number from 0 to 10)

0/10: No Pain ***1-3/10: Minimal Pain*** ***4-6/10: Moderate Pain*** ***7-9/10 Severe Pain*** ***10/10: Need to go to the ER***

My current pain is	0	1	2	3	4	5	6	7	8	9	10
My least amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10
My worst amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10
My average amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10

Do you have times where you are pain free? Yes No

What percent of the time are you pain free? _____%

Pain is: Not changing Getting better Getting worse

What activites are limited or increase your symptoms? _____

_____

_____

What movements/activities help to relieve your symptoms? _____

_____

_____

At the present time, would you say that your health is: Excellent Very Good Good Fair Poor

MODERN PHYSICAL THERAPY

PATIENT HISTORY FORM

Name: _____ **Date:** _____

Age: _____ **Occupation:** _____

Referring Physician: _____

Briefly describe your symptoms: _____

_____

_____

Do you have any numbness/tingling? Yes / No

If so, where? _____

Date your symptoms began: _____

Date of surgery *(if applicable)* **:** _____

What caused your symptoms to begin? _____

_____

_____

Symptoms worsen (*circle which best applies to you*)**:** AM / PM With / Without Activity

What type of diagnostic testing have you had? (*circle*)

X-Rays MRI CT Scan EMG Bone Scan Lab Tests

Date Performed: _____

Results of Imaging: _____

What are your goals with physical therapy? _____

_____

Have you ever had these symptoms before? Yes / No **If so, when?** _____

_____

Please circle any other forms of treatment you have received for this condition:

Injections Surgery Chiropractic Physical Therapy

Other: _____

Have you fallen in the last year? Yes / No

If yes, how many times have you fallen? _____

Were you injured when you fell? _____

WORK REQUIREMENTS (*If applicable*)

How much do you lift in a day? 0-10 pounds 10-20 pounds 20-50 pounds More ____ pounds

How much do you sit in a day? 1/3 day 2/3 day All day

Are you on any restrictions from work at this time? _____

_____

Please indicate specific work tasks that increase your symptoms: _____

_____

MEDICAL HISTORY FORM

For a thorough and complete evaluation, please provide us with this important background information. If you do not understand a question please ask your therapist.

Name: _____ **Date:** _____

List any allergies to medications or other allergies you have: _____

_____

Are you latex sensitive? Yes No

Please circle any of the following whose care you are under:

Medical doctor	Pain Physician	Surgeon
Osteopath	Chiropractor	Neurologist
Psychiatrist/Psychologist	Physical Therapist	Other: _____

Date of last examination by a physician: _____

For the past three months, indicate why you were seen by any of the above medical practioners *(illness, medical condition, etc)*

_____

_____

Tobacco use: How many packs do you smoke per day _____, for how many years_____
If you quit when? _____

Have you EVER been diagnosed with the following conditions?

Y / N	Cancer	If YES, what kind? _____	Y / N	Asthma
Y / N	High Blood Pressure		Y / N	Anxiety
Y / N	Heart Problems	If YES, what kind? _____	Y / N	Arthritis
Y / N	Hepatitis		Y / N	Rheumatoid Arthritis
Y / N	Kidney Disease	If YES, what kind? _____	Y / N	High Cholesterol
Y / N	Circulation Problems		Y / N	Stroke
Y / N	Tuberculosis		Y / N	Diabetes
Y / N	Blood Clots or Difficulty Clotting		Y / N	Multiple Sclerosis
Y / N	Chemical Dependency (i.e. alcoholism)		Y / N	Lyme Disease
Y / N	Thyroid Problems	Hypo or Hyper?	Y / N	Depression
Y / N	Stomach Ulcers	Other: _____		

Please list any significant injuries (fractures, dislocations, etc) or surgeries and their approximate date

_____

_____

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Kansas City, MO 64155
(816) 468-5278

Medication Verification Form

Patient Name: _____DOB: _____

Current Medications including over-the-counter medicines and supplements:

Medication	Dosage	Frequency

Patient Signature: _____Date: _____