KINECT
PHYSICAL THERAPY

Cancellation Policy

We reserve the right to charge $25.00 for a missed appointment without a 24 hour notice.

It is important to note that we pride ourselves in helping people get better. It is impossible to do so if you do not keep your appointments. Help us and you succeed by keeping your appointments.

Signature:_____ Date:_____

950 E Riggs Rd #1 Chandler, AZ 85249 P: 480-802-8730 F: 480-802-8739
4494 W Peoria Ave #115B Glendale, AZ 85302 P: 623-934-1154 F: 623-934-3887
1745 W Hunt Hwy #103 San Tan Valley, AZ 85143 P: 480-568-4580 F: 480-568-4581

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HIPPA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature of Patient or Responsible Party:_____

Relationship to Patient:_____ Date:_____

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PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Referring Physician: _____

Family Physician: _____

Date of First Doctor Visit for this Injury/Episode _____

Have you had any of the following Medical or Rehabilitative Services for ***THIS INJURY/EPISODE?***

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other: _____

Do You Have or Have You Ever Had Any of the Following?

	YES	NO		YES	NO
Asthma, Bronchitis	___	___	Severe or frequent headaches	___	___
Angina	___	___	Emphysema	___	___
Shortness of breath/chest pain	___	___	Vision or hearing difficulties	___	___
Coronary Heart Disease	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight loss/Energy loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemo/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/ Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are you pregnant?	___	___
Emotional/Psychological Dx	___	___	Do you use Tobacco?	___	___

Patient/Guardian Signature: _____ Date: _____

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PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME: _____ AGE:_____ GENDER: __Female __ Male

OCCUPATION: _____ ARE YOU WORKING NOW? __YES __ NO

LAST DATE WORKED:_____

1.	Where is your pain/problem?	
2.	What caused your pain/problem?	
3.	Approximately when did it start?	
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:	
5.	Have you ever had this same (or similar) pain/problem before?	__ Yes (if yes when and describe) __ No
6.	In your understanding, what do you think will make it better?	
7.	How optimistic are you that you will get better? **(circle one)**	Not at all.....Mildly Optimistic.....Fairly.....Very Optimistic.....Extremely
8.	What are some potential obstacles to you getting better?	
9.	Over the next 30 days, how many hours per week will you commit to getting better?	
10.	What are you expecting from therapy?	
11.	On the scale, **circle your worst pain level** in the past couple of days:	Mild Moderate Severe 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
12.	List any medications you are taking	
13.	List all past surgeries with dates:	

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine if I am a viable candidate for a rehabilitation program and the my approval into their program is not guaranteed.

Patient Signature (or guardian): _____ Date: _____