Kinect
PHYSICAL THERAPY & WELLNESS

Dear First Time Patient,

Welcome to the "Kinect" family and thank you for your interest and appointment with us. We look forward to entering with you into a positive and progressive Physical Therapy experience.

Enclosed you will find the necessary paper work that should be completed at the first visit and prior to your evaluation with the Physical Therapist. Please take this opportunity to fill in the paperwork to the best of your ability. Make sure to review each document and sign. Feel free to use our website at kinectphysicaltherapy.com for helpful information. When you arrive for Physical Therapy sessions (including first one), please wear comfortable clothing to be able to exercise in and to easily allow us access to your injury. It will be best to arrive 10-15 minutes before the first appointment (especially if there are any questions with paperwork). Anticipate for your appointments to be about 80 minutes for the first session, unless informed otherwise. Follow up sessions will be made at the end of the first session and are usually expected to be 50 min.

For your appointment please bring:

- Comfortable clothing
- A pair of most commonly worn shoes (for assessment)
- Payment
- Prescription for Physical Therapy in addition to helpful MD, X-ray, MRI and other comparable reports if available
- An open mind to learn something new about yourself.

We look forward to meeting you and working with you towards a positive Physical Therapy experience!

Sincerely,

Kinect Physical Therapy

"EMBRACE A PIVOTAL MOMENT, DISCOVER YOUR POTENTIAL, MAKE A DIFFERENCE"

General Information:

Name: _____Age: _____DOB _____ Gender: M / F

Address:_____City:_____State:_____Zip:_____

Phone:_____e-mail:_____

Spouse / Guardian name:_____May we give them your medical information? Yes / No

Emergency Contact:_____Contact Phone:_____

Diagnosis:_____

Associated MD / health care practitioners in this case:_____

How did you hear about us?_____

Kinect Policies

1. **Cancellation/No Show/Late Notice:** A 50% fee will be charged for the following:
   - If you do not notify us 24 hours in advance to cancel your appointment
   - If you do not show to your scheduled appointment
   - If you are arrive late, the full appointment fee applies

2. **Payment:** The payment is due on each scheduled appointment day.

3. **Proper Clothing:** Please wear clothing that is appropriate for exercise and allows access to your injury.

4. **Cell Phones:** We request that you use your cell phone only for the benefit of your care. We ask that your cell phone is not a distraction to your treatment progression and poses no threat to other patients' privacy.

5. **Family and Friends:** If you have family and/or friends that accompany you, please make sure they are ready to be a valuable part of your healing experience.

6. **Home Exercise Program:** We often include a progressive home exercise / symptom management program as part of your treatment. All should agree that compliance with this process of your care allows for an acceleration towards your goals and quality of life.

Signature _____

Consent to Treat

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at Kinect Physical Therapy & Wellness. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from our services. Therefore, if "hands-on" manual or exercise techniques that are being used to retrain, recruit, and restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them.

This consent shall be ongoing for a period not to exceed one year.

I (or _____ for _____) have read this form and fully understand and accept its terms and conditions.

Patient or Person Authorized to consent for Patient/Relationship Date/Time

Reason patient was unable to consent

Witness Signature

Consent to Treat a Minor *(Fill out only if patient is under the age of 18)**:***
I / We being the parent / legal guardian of a minor age of __ do hereby consent, authorize, and request Kinect Physical Therapy Inc. to administer such treatment as deemed advisable, necessary, or requested for the above named minor. I / we agree to hold Kinect Physical Therapy Inc. free and harmless from any claims, suits, damages or complications which may result from such treatment.

X_____ _____
Signature of Parent / Legal guardian Date

Notice of Privacy Practices - Consent Form:

By my Signature below, I acknowledge that I have been given the opportunity to review the ***Notice of Privacy Practices*** for Kinect Physical Therapy.
(The notice is available for viewing on the waiting room wall, on our website at kinectphysicaltherapy.com, and / or for you to take / view in paper form at our front desk).

X _____
Signature of Patient

Health Questionnaire

Please Fill Out Completely **Date:**_____

Name_____ **Age**_____ **DOB**_____

When did your injury / condition occur? _____, Did it begin ◯ immediately or ◯ gradually.

How did it occur?_____

_____

What body parts were initially painful or affected?_____

_____

What body parts are currently painful or affected? _____

_____

Since this condition / injury began, are your symptoms: ◯ Increasing ◯ Decreasing ◯ No change.

How often do you feel your symptoms?
◯ Occasional (10-25%) ◯ Intermittent (26-50%) ◯ Frequent (51-80%) ◯ Constant (90-100%)

If you have pain, please mark your pain on the scale below. "0" is no pain, "10" is worst pain ever.
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Choose what most accurately describes your symptoms.
◯ Symptoms are noticeable but able to perform all activities.
◯ Symptoms are tolerated but may cause difficulty performing some activities.
◯ Symptoms interfere with performance of all activities.
◯ Symptoms are so severe that you are unable to perform any activity.

What is limited or makes your condition feel worse?

◯ Sitting	◯ Standing	◯ Walking	◯ Running	◯ Stairs
◯ Kneeling	◯ Bending at back	◯ Twisting at back	◯ Lifting	◯ Squatting
◯Repeated motion	◯ Bending at neck	◯ Rotating neck	◯ Desk work	◯ Driving
◯Mental stress	◯ Temperature	◯ Coughing	◯ Sneezing	◯ Other

Other:_____

_____

What activities with your *personal / work* lifestyle are <u>difficult</u> as a result of your symptoms / pain:

1	2
3	4
5	6

What makes your condition feel better?

◯ Rest	◯ Position changes	◯ Standing	◯ Hot compress	◯ Medication
◯ Lying Down	◯ Movement	◯ Exercise	◯ Cold Compress	◯ Stretching
◯ Massage	◯ Manipulation	◯ Knowledge	◯ Sleep	◯ Other

Other:_____

Sleep: ◯ Good ◯ Fair ◯ Poor / **Sleep Position**: ◯ Back ◯ Sides R / L ◯ Stomach ◯ Reclined
Average hours of quality sleep _____.
Activities performed 3 hours before sleep:_____

What treatment have you already received for this condition?

◯ Massage	◯ Surgery	◯ Counseling / Psyc	◯ X-Ray	◯ CT Scan
◯ Chiropractic	◯ Acupuncture	◯ Pain management	◯ MRI	◯ Bone Scan
◯ Injections	◯ Body Work	◯ Personal Training	◯ Sleep Study	◯ Doctor
◯ Other list:				
Medications for this condition:				

General Health (Please check / explain the categories that relate to your health below):

◯ Good	◯ Asthma	◯ Diabetes	◯ TMJ	◯ Cancer
◯ Autoimmune	◯ Gout	◯ Dizziness	◯ Vertigo	◯ Stroke
◯ Osteoarthritis	◯ Pregnant	◯ Post-Partum	◯ Headaches	◯ Short Breath SOB
◯ Rheumatoid Arth	◯ Hernia	◯ Implants	◯ Depression	◯ Vision
◯ Osteoporosis	◯ Digestive	◯ Pacemaker	◯ Bowell difficulty	◯ Bladder Difficulty
◯ Neurological	◯ Painful cycle	◯ Brain Trauma	◯ Concussions	◯ Hearing
◯ Sleep Apnea	◯ Sleep Disturbed	◯ Hormone	◯ Dental	◯ Other

Descriptions of above conditions and others:_____

_____

_____

Heart / Respiratory (Describe): _____

_____

Previous Injuries:_____

_____

All Previous Surgeries:_____

_____

_____

What assistive / adaptive equipment do you use:_____

_____

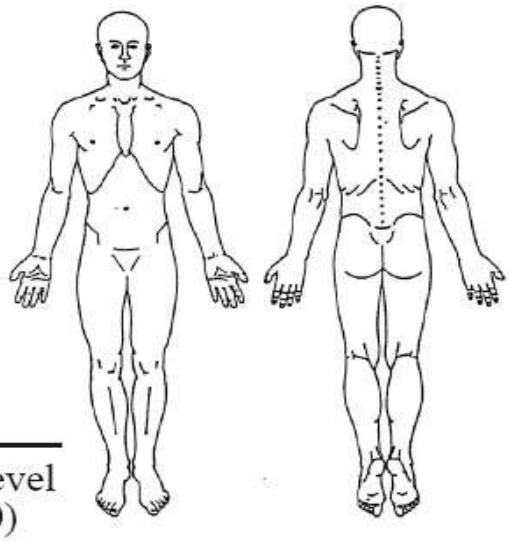
Other Thoughts:_____

_____

Pain/Symptoms

On the Body Diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning



_____
Pain Level
(0-10)

Medications for other conditions

◯ List Provided	1	2	3	4
5	6	7	8	9

Approximately how many glasses of water do you drink per day:____ **Caffeine** Y / N **Smoke** Y / N

Do you have a regular exercise routine? Y / N Describe: _____
_____

Recreational Activities: _____
_____

Are you working? ◯ **Yes** / ◯ **No > Reason:** ◯ **Retired** ◯ **Injury** ◯ **Disability** ◯ **Leave of Absence**
Physical demands specific to your work: _____

_____

Goals with this Physical Therapy experience:

◯ Increase strength	◯ Knowledge	◯ Posture	◯ Symptom control	◯ Exercise
◯ Decrease pain	◯ Body Awareness	◯ Sleep Quality	◯ Balance	◯ Less stress
◯ Other List:				
What activities would you like to perform better:				

Signature:_____ Print Name:_____

"TO THOSE WHO SEEK THE DIFFERENCE, WE'RE AVAILABLE."

Kinect Physical Therapy, Inc. - Statement of Privacy Notice
- For reference only -
Please refer to this document when signing the "Patient Intake Form"

Effective June 1, 2003

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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (831) 250-0005. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (831) 250-0005. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature on the "**Privacy Practices Notice**" section under the "Policies" form, I provide Kinect Physical Therapy, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.