

## **Please Bring to your First Appointment**

1. Photo ID
2. All current Insurance Cards
3. Script from your referring physician for physical therapy
4. Current list of medications
5. Wear comfortable clothing
6. Please Check In at Modern Physical Therapy window when you arrive
7. If you bring x-ray or MRI films please be sure to take them home with you



## 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 \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

### 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 health care provider. The following is our **Financial Policy**. If you have any questions or concerns about our payment policies please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the physical therapist.

**Patient's portion of payment is due at the time of service unless prior arrangements have been made with the business office manager.**

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are **NOT** a party to that contract. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not.
3. **Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment. If you have accrued a balance of over \$100.00, payment is due at the time of service.**
4. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. If for any reason your insurance has changed, Modern Physical Therapy expects to be updated immediately.
6. Returned checks will be subject to **\$30.00** collection charge. We will notify you by telephone contact or by certified letter. If the check is not picked up within 10 days the check will be turned over to law enforcement.
7. Unpaid balances over **60** days will be charged a **\$5.00** late fee.
8. Unpaid balances over **90** days are subject to collections via small claims court, attorney, and/or collection agency with applicable delinquent account interest. Accrued interest is the responsibility of the patient.
9. There will be a **\$25.00** service charge for any No Show appointment.
10. If cancellation occurs with less than 24 hour notice a **\$25.00** fee will apply and will be due prior to further treatments. If excessive cancellations occur, to continue treatment you will be expected to call the day of treatment to schedule an appointment.
11. No Show and cancellation fees are the patient's responsibility and will not be submitted to insurance companies or waived due to financial hardship.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

**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.

This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment.

\_\_\_\_\_  
**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  
9501 N. Oak Trafficway, Suite 201  
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



9501 N. Oak Trafficway, Suite 201  
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 \_\_\_\_\_



## PATIENT HISTORY FORM

Date: \_\_\_\_\_

**NAME:** \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Symptoms:**

Referring Physician: \_\_\_\_\_

Briefly describe your symptoms: \_\_\_\_\_

\_\_\_\_\_

Date your pain began: \_\_\_\_\_

How did your pain begin? \_\_\_\_\_

\_\_\_\_\_

Do you have any weakness? Yes/No Where? \_\_\_\_\_

\_\_\_\_\_

Do you have any numbness? Yes/No Where? \_\_\_\_\_

\_\_\_\_\_

How often do you have symptoms? \_\_\_\_\_

Symptoms worsen: AM/PM With/Without Activity

What are 3 movements/activities that increase your pain? \_\_\_\_\_

\_\_\_\_\_

What movements/activities help to relieve your pain? \_\_\_\_\_

\_\_\_\_\_

How much have your symptoms interfered with your usual daily activities? (circle)

Not at all    A little bit    Moderately    Quite a bit    Extremely

Have you ever had similar symptoms before? Yes/No When? \_\_\_\_\_

\_\_\_\_\_

Previous treatment of this condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Trauma or accident prior this condition: \_\_\_\_\_  
\_\_\_\_\_

Who have you seen for this condition? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Changes in daily life since symptoms began (new job, caregiving, etc) \_\_\_\_\_  
\_\_\_\_\_

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

X-Rays   CT Scan   MRI   EMG   Bone Scan   Lab Test

Date performed:   \_\_\_\_\_   \_\_\_\_\_   \_\_\_\_\_   \_\_\_\_\_   \_\_\_\_\_   \_\_\_\_\_

Goals for treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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

Does your job require repetitive tasks?   Yes/No   If so, what? \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

Allergies: 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 practitioners  
(illness, medical condition, etc)

During the past month have you been feeling down, depressed or hopeless? Yes / No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes / No

How many caffeine containing beverages do you drink per day? \_\_\_\_\_

Tobacco use: How many packs do you smoke per day \_\_\_\_\_ for how many years \_\_\_\_\_

If you quit when? \_\_\_\_\_

Please list or let the front office make a copy of the list of medications you are currently taking

(include dosages of pills, injections, and patches) \_\_\_\_\_

Which of the following medications have you taken in the last week?

	Physician Prescribed	Dosage
Aspirin, Advil, Motrin, Ibuprofen, etc	Yes / No	_____
Tylenol	Yes / No	_____
Stomach ulcer medications	Yes / No	_____
Vitamins, minerals, herbal remedies	Yes / No	_____
Other medications NOT prescribed by a physician:		_____

Have you EVER been diagnosed with the following conditions?

**You**

Y / N Cancer If YES what kind? \_\_\_\_\_

Y / N High blood Pressure

Y / N Heart Problems If YES what kind? \_\_\_\_\_

Y / N Hepatitis

Y / N Tuberculosis

Y / N Stroke

Y / N Kidney disease If YES what kind? \_\_\_\_\_

Y / N Blood clots

Y / N Chemical dependency (i.e. alcoholism)

Other \_\_\_\_\_

Y / N Circulation Problems

Y / N Asthma

Y / N Stomach Ulcers

Y / N Osteoporosis

Y / N Thyroid problems

Y / N Diabetes

Y / N Multiple sclerosis

Y / N Rheumatoid arthritis

Y / N Other arthritic conditions

Y / N Depression

Please circle any of the following that are NEW or UNUSUAL for you

Y / N weight loss/gain	Y / N joint/muscle swelling	Y / N problems sleeping
Y / N nausea/vomiting	Y / N easy bruising	Y / N sexual difficulties
Y / N dizziness/lightheadedness	Y / N excessive bleeding	Y / N night sweats
Y / N fatigue	Y / N difficulty breathing	Y / N hearing problems
Y / N weakness	Y / N regular cough	Y / N urinary incontinence
Y / N fever/chills/sweats	Y / N arm/leg swelling	Y / N blood in urine
Y / N numbness or tingling	Y / N heart racing in your chest	Y / N pregnant or may be
Y / N tremors	Y / N difficulty swallowing	Y / N stress at home or work
Y / N seizures	Y / N heartburn/indigestion	Y / N blood in stools
Y / N double vision or loss of vision	Y / N constipation/diarrhea	Y / N post menopause
Y / N eye redness	Y / N skin rash	Y / N problems urinating

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

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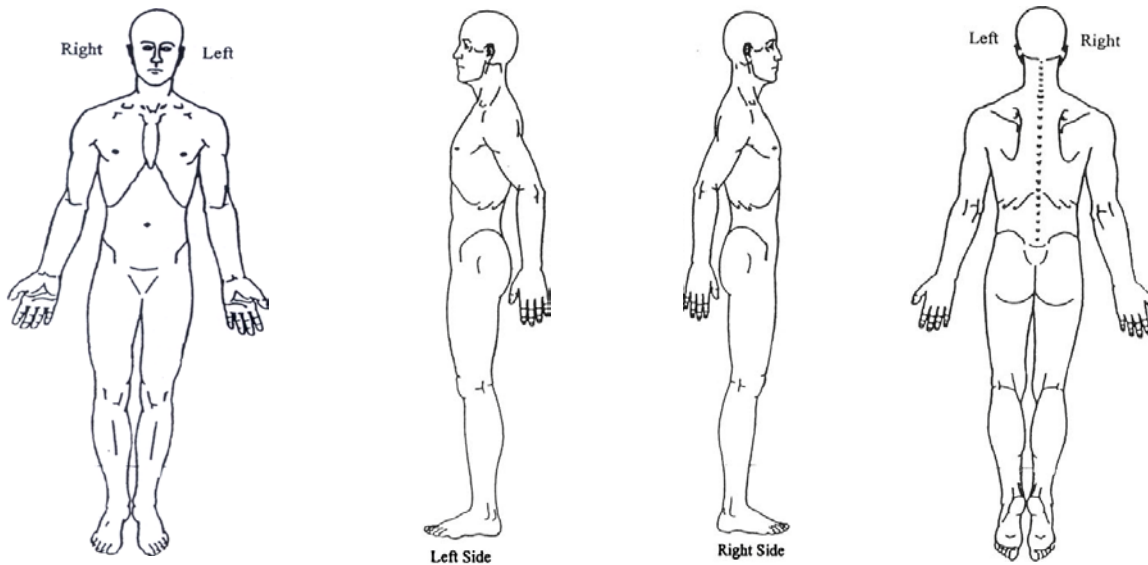
Therapist Signature \_\_\_\_\_

Patient Signature \_\_\_\_\_



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please fill in your area(s) of discomfort / symptoms. Do not use circles or X's. Instead, color in the areas(s) with a pen, as if you were drawing in a children's coloring book. Be as precise as you can about the exact area the symptoms occupy and what their boundaries are. Write in descriptive words where necessary (dull, sharp, better, worse, numbness, tingling, etc.). This form is a tool for you to communicate with us about progress and changes in your condition.



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

My current pain is	No pain: 0 1 2 3 4 5 6 7 8 9 10 :Extreme pain
My best pain over last week	No pain: 0 1 2 3 4 5 6 7 8 9 10 :Extreme pain
My worst pain over last week	No pain: 0 1 2 3 4 5 6 7 8 9 10 :Extreme pain
My average pain over last week	No pain: 0 1 2 3 4 5 6 7 8 9 10 :Extreme pain

**Pain is:** Not changing    Getting better    Getting worse

**What activities increase symptoms?** \_\_\_\_\_  
 \_\_\_\_\_

**What activities are limited due to symptoms?** \_\_\_\_\_  
 \_\_\_\_\_