KONIUTO MOVEMENT PT

Patient Information Form

Last Name_____ First Name_____ MI_____

Address_____ City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ Gender _____ Marital Status _____

Email _____
(Please provide email if you want statements to be sent to you directly after service)

Emergency Contact / Responsible Party if Minor

Last Name _____ First Name _____

Relationship _____ Phone _____

Problem

Problem Description _____ Date of Injury _____

What products / supplements are you using to help your problem get better? _____

_____

Primary Care Physician _____ Phone _____

Last Physician Visit _____ Referred By _____

PT Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

Past/Present medical conditions (circle answer below):

Asthma	No/Past/Present/Family	Epilepsy/Seizures	No/Past/Present/Family	Kidney Disease	No/Past/Present/Family
Arthritis	No/Past/Present/Family	Extremity Swelling	No/Past/Present/Family	Metal/Other implants	No/Past/Present/Family
Bowel Dysfunction	No/Past/Present/Family	Fainting	No/Past/Present/Family	Multiple Sclerosis	No/Past/Present/Family
Cancer	No/Past/Present/Family	Fever/Chills	No/Past/Present/Family	Osteopenia/Osteoporosis	No/Past/Present/Family
Chemical Dependency	No/Past/Present/Family	Fibromyalgia	No/Past/Present/Family	Pacemaker	No/Past/Present/Family
Chest Pain/Discomfort	No/Past/Present/Family	Fracture	No/Past/Present/Family	Pregnancy	No/Past/Present/Family
Circulatory Disease	No/Past/Present/Family	Headache	No/Past/Present/Family	Shortness of Breath	No/Past/Present/Family
Depression	No/Past/Present/Family	Hearing Implants	No/Past/Present/Family	Stroke	No/Past/Present/Family
Diabetes	No/Past/Present/Family	Heart Attack	No/Past/Present/Family	Thyroid Problems	No/Past/Present/Family
Diarrhea	No/Past/Present/Family	Heart Disease	No/Past/Present/Family	Visual Impairments	No/Past/Present/Family
Dizziness	No/Past/Present/Family	Hepatitis	No/Past/Present/Family	Unexplained weight change	No/Past/Present/Family
Difficulty Urinating	No/Past/Present/Family	Hernia	No/Past/Present/Family	Urinary frequency changes	No/Past/Present/Family
Eating Disorder	No/Past/Present/Family	High Blood Pressure	No/Past/Present/Family	Other_____	No/Past/Present/Family
Emphysema	No/Past/Present/Family	Infectious Disease	No/Past/Present/Family	Other_____	No/Past/Present/Family

Medical /SurgicalHistory (Sprains, fractures, illnesses, etc): _____

_____

Medications / supplements (Include current list and past long -term use): _____

_____

Allergies and Reactions: _____

Do you use: Tobacco Yes/No Frequency_____ Caffeine Yes/No Freq _____ Alcohol Yes/No Freq _____

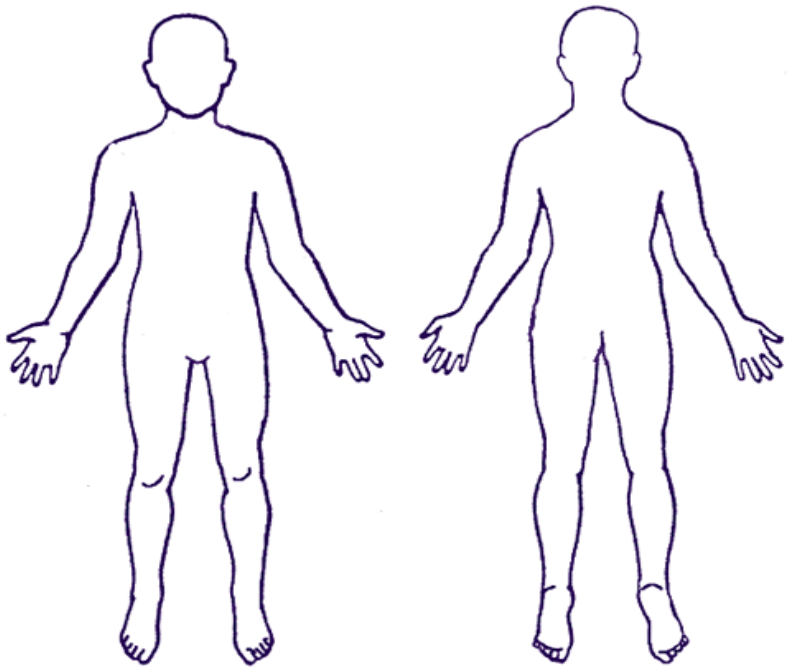
X-Ray Y/N: **When/Where**_____ MRI: Y/N **When/Where** _____ CT Scan: Y/N When/Where_____

Current Condition: What injury / problem / complaint has brought you to physical therapy today: _____

_____

When and how did this problem begin: _____

What makes it better:_____ Worse: _____ Location of pain: _____



KMPT RELEASE / FINANCIAL POLICY / HIPPA POLICY

TO OBTAIN AND RELEASE MEDICAL INFORMATION:

This signed document, copy of same, will authorize you to furnish Koniuto Movement PT, or its representative, any or all information in your possession regarding the above-named patient's condition while under your care or treatment, including the history obtained, diagnostic imaging (i.e.: x-ray, MRI, etc…) (includes obtaining copy of original films/discs), physical and laboratory findings, diagnosis and prognosis.

OFFICE USE ONLY

☐ OP REPORT ☐ MRI ☐ XRAY REPORT ☐ CT SCAN ☐ OTHER_____

Patient's printed name: _____DOB: _____

Patient's signature: _____ Date: _____
(Parent/Guardian if Minor)

HIPPA

Please sign that you have been made aware of Koniuto Movement PT HIPPA compliance policies. You can find all our HIPPA Policies located in a binder in our waiting area for your review. Should you need a copy please request one from our front desk.

CANCELLATION / NO SHOW POLICY

Please note that Koniuto Movement PT has a 24-hour cancellation policy. You will be charged the full visit fee should you not provide the required 24 hour notice of cancellation.

ASSIGNMENTS OF INSURANCE BENEFITS AND PATIENT RESPONSIBILITY

If Medicare is my primary insurance carrier, I will sign this form, in order to authorize Oakdale Physical Therapy & Fitness to submit medical claims on my behalf to my insurance provider. I understand that it is my responsibility to notify Koniuto Movement PT / Oakdale Physical Therapy & Fitness of any changes to my insurance carrier or coverage as soon as possible. Any failure to report such changes will result in the patient being financially responsible for any lapse in coverage or authorization. Koniuto Movement Physical Therapy visits are NON- Refundable by insurance. This is a self pay rate only visit.

ALL PAYMENTS should be paid at time of service at check in. More information regarding our policy can be found in the white binder in our waiting area. Should you need a copy please request one from our front desk.

I understand that I have the right to obtain a copy of Koniuto Movement PT and Oakdale Physical Therapy & Fitness Notice of Privacy Practices and any files as stated above.

_____ _____

PRINTED NAME OF PATIENT **SIGNATURE OF PATIENT (or Parent/Guardian if Minor)**

Koniuto Movement PT
CONDITIONS OF ADMISSION

1. **CONSENT TO TREATMENT:** Consent is hereby given to Koniuto Movement PT and to all health care professionals using its facilities to provide such rehabilitative care and to administer such routine diagnostic and/or therapeutic procedures and treatment as are deemed to be necessary for the health and welfare of the below-named patient. As the practice of medicine and rehabilitation is not an exact science, no guarantee or assurance of beneficial results has been promised or implied as a result of the above-mentioned diagnostic and therapeutic procedures.

2. **RELEASE OF INFORMATION:** Koniuto Movement PT may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the patient or to a family member or employer of the patient for all or part of Koniuto Movement PT charge, including but not limited to hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds or the patient's employer. Koniuto Movement PT may disclose all or part of the patient's chart to other providers of health care goods and services, in order to make arrangements for coordinated health care delivery. **KMPT may disclose medical information to the following**:_____

   _____

   _____

3. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates him/herself to pay the account of Koniuto Movement PT (KMPT) in accordance with the regular rates and terms of Koniuto Movement PT. KMPT accepts direct payment at time of treatment and accepts all major forms of payment, including pre-tax medical spending account debit cards. KMPT visits are not insurance reimbursable. This is a self pay rate only. Our goal is to provide quality care that saves you money in the long run.

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof, and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

Patient Signature_____ Date: _____

Patients Parent/Guardian (if Minor): _____

Relationship to Patient _____

KONIUTO MOVEMENT PT
FEE SCHEDULE & POLICIES

- Koniuto Movement PT is a self pay provider. PT visits are non-refundable by insurance companies.
- Koniuto Movement PT is not a Medicare Provider and does not accept assignment from Medicare. However, OPTF is a Medicare Provider and may be billed by John Koniuto, DPT
- Payment may be made by either, cash, credit card or personal check at time of visit.
- Payment is to be made at time of service.
- Koniuto Movement PT is not responsible for any inquiry to your insurer regarding your policy &/or benefits.
- Koniuto Movement PT is not responsible for any submission of fees to your insurer for payment of services rendered. KMPT visits are not billable or reimbursable by your insurance company.
- All cancellations are to be made at least 24 hours prior to your scheduled appointment. It is imperative that you are fully accountable for keeping the appointments that you schedule with your therapist.
- If appointments are cancelled less then 24 hours prior to the appointment and not rescheduled, the full treatment fee will be charged.
- If a client is a "no-show," the full treatment fee will be charged.
- A "no-show" is defined as an appointment that is made, not cancelled at least 24 hours prior, and is not attended at the scheduled time.
- If your treating therapist has to cancel the treatment session for any reason, there will be no charge for that session and it may be rescheduled at a convenient time for you.

Treatment fee schedule

• **Consultation**	**no charge**
• **Initial Evaluation (1 hr):**	**$180.00**
• **1 hour Treatment:**	**$150.00**
• **15 minute RockTape Session**	**$25.00**

*$50 fee added to all out of office sessions due to travel time and time out of office

I have read the above and agree to abide by the statements written herein.

Print Client Name: _____

Client Signature: _____ Date: _____
(Parent / Guardian if Minor)

Koniuto Movement PT

PERMISSION TO HOLD CREDIT CARD ON FILE

TODAY'S DATE: _____

I, _____, authorize Koniuto Movement PT to charge my credit card:

___VISA
___MasterCard
___Discover Card
___American Express

CREDIT CARD NUMBER: _____
EXP DATE: ____/___ CID # _____ (3 digit number on back of card)

I GRANT KONIUTO MOVEMENT PT / *PHYSICAL THERAPY @ OAKDALE, PLLC* AUTHORIZATION TO CHARGE MY CREDIT CARD FOR SERVICES I HAVE REQUESTED UNTIL I NOTIFY THEM OF A NEW CREDIT CARD TO REPLACE THIS AUTHORIZATION OR THROUGH THE COMPLETION OF SERVICES.

CARDHOLDER SIGNATURE: _____

CARDHOLDER BILLING ADDRESS:

_____

_____

CARDHOLDER PHONE NUMBER: _____