



KING PHYSICAL THERAPY

Welcome to King Physical Therapy. Please, let us know if we can assist you as you answer the following questions. We hope your experience with us will be pleasant.

PATIENT DEMOGRAPHICS

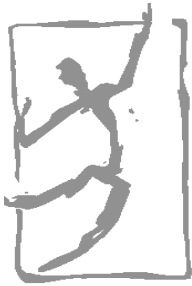
Today's Date: _____ Patient's Full Name: _____
D.O.B.: _____ Gender: M F SSN: _____
Street Address: _____ City: _____
State: _____ Zip: _____ Email Address: _____
Home Phone: _____ Work: _____ Mobile: _____
Employer/School: _____ Occupation: _____
Employer's Address: _____
Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work: _____ Mobile: _____
Name of Insured (if different): _____
Insured's SSN: _____ Insured's D.O.B.: _____

INJURY OR ILLNESS RELATED INFORMATION

Date of onset/injury: _____ Is this a work related injury? Yes No
If yes, has your treatment been approved by workers compensation? Yes No
Worker's Compensation claim number: _____ State: _____
Address where claims are to be mailed _____
Is this an auto-related injury? Yes No
If yes, has your treatment been approved by your auto insurance? Yes No
Claim Number: _____ Insurance Name: _____
Is this case under litigation? Yes No Attorneys Name: _____
Referring Physician: _____ Date Last Seen: _____
Primary Physician: _____ Date Last Seen: _____

Who/what influenced you to choose KPT for your rehabilitation?

Physician: _____ Friend or Family _____ Brochure: _____
Newspaper: _____ Phone Book: _____ Other: _____



King Physical Therapy

FINANCIAL POLICY/CONTRACT & ASSIGNMENT OF BENEFITS

King Physical Therapy will bill your insurance at no charge, as a courtesy to you. As a patient, you are responsible for knowing what is covered or required by your insurance company or worker's compensation carrier. As a service to our patients we confirm authorization for your treatment and check on benefit coverage. This information will be shared with you at your first or second visit. Please be aware that you are ultimately responsible for all charges.

- Not all services are a covered benefit in all policies, and/or you may be limited to a certain quantity or dollar amount. You are responsible for the percentage not covered by your insurance.

- All co-pays are due at the time of your appointment. Please pay the receptionist prior to your visit. (_____)

- We should receive payment from your insurance company within 60 days. After 60 days, you are responsible for the balance.

- You will receive a statement once every month indicating the balance due. We accept cash, personal check, Visa or MasterCard. Any accounts not paid within 120 days will be referred to an outside collection agency. (_____)

- If your account is referred for collection, you will be responsible for the balance due, plus 33.33% as a collection fee.

- If you are not able to keep your scheduled appointment, please call our office at least 24 hours in advance so that your appointment time may be given to someone else. There will be a \$25.00 fee for missed appointments without notification. This is NOT paid by insurance. (_____)

- I hereby assign, and set forth to **King Physical Therapy**, sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care, to cover the costs of care and treatment rendered to myself or my dependent. I understand I am financially responsible to **King Physical Therapy** for charges not covered by this authorization.

Signature of Patient or Responsible Party

Date



King Physical Therapy

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize release of my individually identifiable health information for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that I receive. Continuity of care is part of treatment and my records may be shared with other providers to whom I am referred from or referred to. This information may be shared by paper mail, electronic mail, FAX, or other methods. I understand that my healthcare and the payment for my healthcare will not be affected by signing this form.

I have been given a copy of the **King Physical Therapy Patient Privacy Policy**. I also understand that I may revoke this authorization at any time in writing, but it will not have any affect on any actions they took before they receive the revocation.

Signature of Patient or Responsible Party

Date

Patient Intake Questionnaire

King Physcail Therapy

772 Foxcroft Ave. # 14
Martinsburg, WV. 25401

Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: _____

About your current complaint...

1 What is the complaint that brought you here? _____

2 When did this complaint begin, or recently become worse? Approximate Date: _____

3 What caused this complaint? _____

4 Does this complaint affect your activity choice, tolerance, efficiency or effectiveness? Yes No

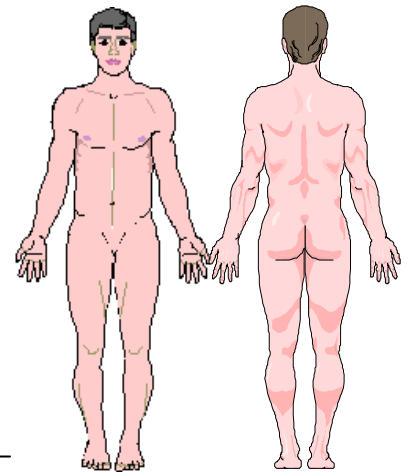
If "Yes", what activities? _____

5 What makes this complaint better? _____ Worse? _____

6 Does this complaint affect your comfort, mood or ability to sleep? Yes No

7 What symptoms are you experiencing with this complaint?

- Swelling
- Loss of motion
- Weakness
- Loss of balance or coordination
- Numbness
- Tingling
- Pain: Draw pain areas on body diagrams...
- Other (Specify) _____



8 How frequent are the symptoms experienced?

- Constant
- Intermittant

9 How much pain are you experiencing?

- None
- Very Mild
- Mild
- Moderate
- Severe
- Very Severe

10 What tests have you had for this complaint?

- XRay
- CAT Scan
- MRI
- Myelogram
- Bone Scan

11 What treatment have you had for this complaint? Physical Therapy Occupational Therapy

- Athletic Training
- Chiropractic
- Alternative Medicine - (Specify): _____

12 Is this complaint work related? Yes No

If "Yes", your employer's name: _____ Your Occupation: _____

Work Status: Full Time Part Time Working Medical Restrictions Medical Leave Last Date Worked: _____

13 Is this complaint auto related? Yes No

About your general health...

14 Please check all medical conditions that you have, or have had.

- Arthritis
- Cancer
- Diabetes
- Stroke
- Heart Disease
- High Blood Pressure
- Lung Disease
- Thyroid Problems
- Pace Maker
- Stomach Disorder
- Anxiety
- Depression
- Panic Attacks
- Other: _____

15 Please check all of the following items that currently apply to you.

- Hearing Problems
- Visual Problems
- Learning Problems
- Pregnant
- Bowel or bladder control
- Smoke

16 Please list surgeries: _____

17 Please list allergies: _____

18 Please list medications you are currently taking?

19 Are you currently receiving psychosocial services? Yes No

20 Is there any other information you think we should know? Yes No

King Physical Therapy , Inc
772 Foxcroft Ave. #14
Martinsburg, WV 25401

NOTICE OF PROTECTED HEALTH INFORMATION 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.

Permitted Uses and Disclosures of Your Health Information

1. Uses and Disclosures with Patient Consent: Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

a. Treatment. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physical therapist may disclose your health information when consulting with a physician regarding your medical condition.

b. Payment. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies or portions of your

medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedure; and supplies used in your treatment,-

c. Health Care Operations. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

Uses and Disclosures With Patient Authorization. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

Uses and Disclosures With Patient Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

a. Uses and Disclosures Required by Law. We will disclose your health information when required to do so by law.

b. Public Health Activities. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

c. Abuse and Neglect. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

d. Regulator/Agencies. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

e. Judicial and Administrative Proceedings. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

f. Law Enforcement Purposes. We may disclose your health information to law enforcement officials when required to do so by law.

g. Coroners, Medical Examiners, Funeral Directors. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

- h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information. .
 - i. **Threats to Health and Safety.** We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
 - j. **Military/Veterans.** If you are a member of the armed forces, we may disclose your health information as required by military command authorities.
 - k. **Workers' Compensation.** We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
 - l. **Marketing.** We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.
 - m. **Appointment Reminders.** We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.
 - n. **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.
5. **Uses and Disclosures to Business Associates.** With an acknowledgement or a proper authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity, which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business A Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request. If, however, we agree to the requested restriction, it is binding on us.
2. **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.
3. **Right to Verbally Object.** You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.
4. **Right to Seek an Amendment of Your Health Information.** You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.
5. **Right to an Accounting of Disclosure of Your Health information.** You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request; provided, however that we need not provide an accounting for any information disclosed prior to April 14, 2003, The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to the April 14,2003 compliance deadline under the Privacy Regulations. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.
6. **Right to Confidential Communications.** You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.
7. **Right to Revoke Your Authorization.** You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.
8. **Right to Receive Copy of this Notice.** You have the right to receive a copy of this Notice.

Contact information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact Zach Marshall at (304-262-8161) moreover, the Practice has established an internal complaint process for reporting privacy rights violations- If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact Zach Marshall at (304-262-8161) All complaints must be submitted to the Practice in writing at 772 Foxcroft Ave. #14 Martinsburg, WV 25401. There will be no retaliation for filing a complaint.

Effective Date of this notice is March 1, 2005