PHYSICAL THERAPY
KINETIX PT
Steve Hodgson MPT

Kinetix Pt Patient Information

NAME_____ **DOB** _____

ADDRESS_____ **CITY**_____**ZIP**_____

PHONE-HOME_____**CELL**_____ **WORK**_____

EMAIL_____ **HOW DID YOU HEAR ABOUT US?**_____

EMPLOYER_____ **OCCUPATION**_____

DATE OF ONSET_____ **DATE OF SURGERY**_____

REFERRING MD _____ **PRIMARY MD** _____

Have you had physical therapy this calendar year here, or at another office? Yes No

Insurance Info

INSURANCE CO_____ **MOTOR VEHICLE ACCIDENT?** _____

NAME OF INSURED_____**DOB**_____

EMERGENCY CONTACT:

NAME_____ **PHONE**_____

If Patient Is A Minor, Please Provide The Following Information:

PARENTS / GUARDIAN NAME _____**PHONE-HOME**_____

CELL_____**WORK** _____

- **I HEREBY AUTHORIZE KINETIX PT TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN.**
- **I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO BE PAID DIRECTLY TO KINETIX PT.**
- **I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS, AND OTHER PERTINENT INFORMATION TO KINETIX PT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.**
- **I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY PAY, CO-INSURANCE, OR DEDUCTIBLE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**
- **I UNDERSTAND THAT THERE WILL BE A $10.00 SERVICE CHARGE ON ALL RETURNED CHECKS.**
- **I HAVE READ AND FULLY UNDERSTAND KINETIX PT'S NOTICE OF INFORMATION PRACTICES**

SIGNATURE OF PATIENT / GUARDIAN _____ **DATE** _____

(FOR OFFICE USE ONLY)

CO-PAY _____ **CO-INSURANCE** _____ **DEDUCTIBLE**_____

DEDUCTIBLE MET?_____**SIGNATURE**_____