Are you a returning patient? _____Yes No_____ If "Yes" last date treated at KPT: _____/_____/_____

Patient_____
Last First M.I.

Parent/Guardian: _____
Last First MI

Address_____

City_____**State**_____**ZipCode**_____

Phone Home _____**Work** _____**Cell** _____

Date of birth _____/_____/_____ **Sex: M F** (circle) **E-mail** _____

Social Security# _____ - _____ - _____ **(If the patient is a MINOR the SS# of the parent/guardian)**

Emergency Contact (name, address, phone # **REQUIRED)**_____

_____

NO VERBAL CHANGES ALLOWED. ALL PATIENTS MUST READ AND SIGN BELOW:

If a third party is to be billed (including all insurance and managed care): I do hereby grant a power of attorney to Kensington Physical Therapy Inc. (KPT), its staff, and billing service, which is SPECIFICALLY LIMITED to entitle them to sign my name to any insurance claim form, PIP form, or other document, for the purpose of submission and processing of benefits which may be due or owed to me or patient under any policy of insurance, or any means of third party payment.

If the patient has a **heart pacemaker** or any **metal implant**, or becomes **pregnant** I will inform the therapist. If the patient is a **minor** I do hereby certify that I am a parent or legally appointed guardian of said minor, and I do hereby grant permission for medical treatment of said minor. I agree to allow e-mail to me for appointment reminders, newsletters, and other notices.

I assign payment of benefits to KPT. I authorize release of medical information about the patient. I agree, in the event of default in the payment of any amount due, that I will pay an additional charge for the cost of collection including, but not limited to, agency, attorney, court, and KPT administrative costs. I hereby waive the defense of the Statute of Limitations for any claim filed against me beyond any statutory period after the date services were rendered. I agree to a missed appointment fee of $20.00 if I do not give at least 24 hours notice. I am financially responsible and will pay for any service denied by any third party payer (including missed appointments fees), or not fully paid by insurance within 60 days of KPT's billing. Payments on my behalf of a lesser amount than the full balance due shall be deemed to be "on account." No endorsement or statement on or accompanying any payment of less than the full balance due shall render it payment in full, and KPT may accept such payment without prejudice to KPT's right to recover the balance owed or to pursue any other legal remedy. I agree that when sixty days have elapsed since my last treatment, interest may be charged against, and added to, the outstanding balance at 1.5% monthly percentage rate, compounded monthly. I agree that service of legal process by first class and certified mail to my last known address shall be valid service. A copy of this form shall be as valid as the original. I hereby consent to treatment of the patient and submission of claims to third parties. I understand that the patient's records may be destroyed after three years. I agree to the application of payments on my behalf, first to interest, and then to principal. If third party payers are involved, I understand that information given to KPT by telephone is sometimes not accurate and as a result, I may owe KPT more than originally quoted to KPT. If I should recover benefits from PIP and/or liability carrier(s), or other third party payers, I authorize and direct full payment to KPT, regardless of whether in the meantime KPT has accepted managed care benefits and made adjustments to my account as per the managed care "fee schedule."

If Medicare: I understand that I must pay charges not covered by Medicare. _____ By my initials I state that, within the last 4 months, I have not been seen by any home health agency that bills through Medicare. I will inform KPT if I have home health visits.

Responsible
Party's
Signature: _____(Seal) Date: _____
(Parent/Guardian's signature if patient is under 18)

Description of what caused you to seek treatment: _____

_____

Is this injury related in any way to a:

Motor vehicle accident _____Yes No_____
If yes, were you the driver: _____Yes No _____ OR were you a passenger: _____Yes No _____

Work related accident of any kind (including motor vehicle)? ____Yes No____

Employer _____
Always required information if work related (Name and Phone #)

Address: _____

Referring physician: _____

Physician's phone numbers: _____ _____

Physician's Rx (if you can read it) _____

Diagnoses (if known): _____

Onset/First symptom date _____ - _____ - _____

Attorney:_____ Phone: _____

Insurance: _____ ID#_____

Insurance phone #s_____

How did you hear about KPT? (circle one) M.D. Friend/Family Attorney Other

Other Information: _____

_____

When would be the best time of day for your treatment? _____

Patient (last, first, mi): _____date: _____

CALL US AT 301-657-0030 WITH ANY QUESTIONS!

PLEASE BRING TO FIRST VISIT (if you have them):

- ❑ an interpreter if you choose to do so,
- ❑ prescriptions and "referral forms" for therapy,
- ❑ a photo ID card,
- ❑ all insurance cards and forms,
- ❑ list of medications, surgeries, fractures,
- ❑ info about injuries, major diseases, and
- ❑ MRI and x-ray reports, docs' notes, evaluations.

FAX ALL PAGES OF THIS FORM TO KPT AT 301-657-0031