Registration for Services at Kempton Physical Therapy

Welcome to our office. In order to serve you properly, we will need the following information.**(Please Print)** All information will be strictly confidential.

Last Name:	First Name:		MI:
Address:	City:	State:	Zip Code:
Patient's Social Security #:	Home Phone:	Cell Phone:	Birth date:
Referred by: Dr._____ Family Member _____Friend_____ Walk In_____ Previous Patient_____ Internet_____		Sex: M F	Marital Status: M S W D
What type of condition/ injury are you being seen for:	Name of Referring Physician:		
Date of Injury/ First Symptoms:	Employment Related? Y N	Auto Accident? Y N	Other?
Have you had any therapy/chiropractic this calendar year? Y N	If so, how many visits?	Was the therapy performed at your home? Y N	
Name of Employer:	City & State:	Work Phone:	Ext:
Person to contact in case of emergency:		Phone #:	
Primary Insurance Company: /	Secondary Insurance Company:	Is the insurance in your name? Y N	
Personal email address:		☐ I want to receive reminders for my appointments ☐ I want to receive email communications	
Name of insured, if not self:	Relationship to insured:	Insured social security #:	
Birth date of insured:	Insured employer name:		

Please ***INITIAL*** in applicable spaces below.

_____ I have read and understand the Patient Rights and Responsibilities.

_____ I have read and understand the procedure for filing a concern.

_____ I have read and understand the Notice of Privacy Practices in protecting my health information.

Authorization for Assignment of Benefits/Information Release:

I, the undersigned, give consent for physical therapy and authorize payment of medical benefits to Kempton Physical Therapy for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I also give permission to call my cellular and home phone to contact me and/or leave a detailed message.

_____ _____

Patient Signature Date

6960 E. Broadway Rd. Mesa, AZ 85208 • 1100 N. Broad St. Suite A Globe, AZ 85501
Phone (480) 807-9000 • Fax (480) 807-9234

KEMPTON Physical Therapy
SPORTS MEDICINE & REHABILITATION SPECIALISTS

Patient Name: _____

Age: _____ Current weight: _____ Height: _____

Current Medications: ☐ **I do not take any medications**

Name of Medication	Dose	How Often Taken

Recent Hospitalizations/ Surgeries (within past year): ☐ **None**

Description	Date

Injuries/ Illnesses: Please check if you have ever had:

☐ Arthritis	☐ Broken bones/fractures	☐ Osteoporosis
☐ Blood disorders	☐ Circulation/vascular problems	☐ Heart problems
☐ High blood pressure	☐ Lung problems	☐ Stroke
☐ Diabetes/high blood sugar	☐ Hypoglycemia/low blood sugar	☐ Head injury
☐ Multiple sclerosis	☐ Muscular dystrophy	☐ Parkinson's disease
☐ Seizures/epilepsy	☐ Allergies	☐ Developmental/growth problems
☐ Thyroid problems	☐ Cancer	☐ Infectious disease (e.g. tuberculosis, hepatitis)
☐ Kidney problems	☐ Repeated infections	☐ Ulcers/Stomach problems
☐ Skin diseases	☐ Depression	☐ Pacemaker

☐ Other: _____

Within the past year, have you had any of the following symptoms? (Please check all that apply)

☐ Chest pain	☐ Heart palpitations	☐ Cough
☐ Hoarseness	☐ Shortness of breath	☐ Dizziness or blackouts
☐ Coordination problems	☐ Weakness in arms or legs	☐ Loss of Balance
☐ Difficulty walking	☐ Joint pain or swelling	☐ Pain at night
☐ Difficulty sleeping	☐ Loss of appetite	☐ Nausea/vomiting
☐ Difficulty swallowing	☐ Bowel problems	☐ Weight loss/gain
☐ Urinary problems	☐ Fever/chills/sweats	☐ Other: _____

Signature: _____ Date: _____

1. Date injury/problem occurred:
___/____/____

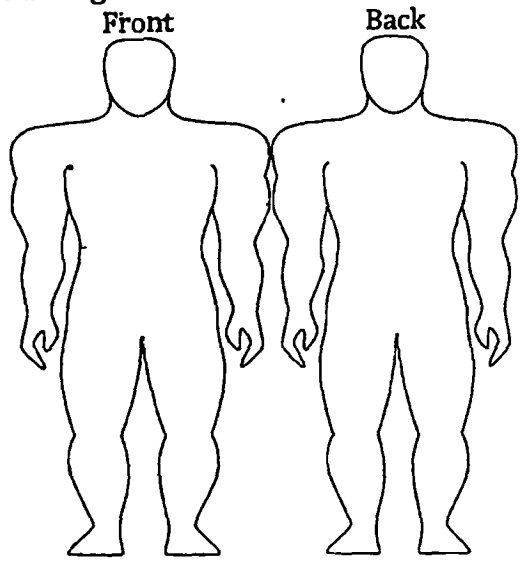
2. Date of last doctor's visit:
___/___/____

3. When is your next Dr. visit?
___/____/_____

4. Briefly explain how your problem occurred:

_____
_____
_____
_____
_____

Please draw or circle where you are hurting



5. What is your pain on a scale from 0-10 (0=no pain, 10=worst pain)
Current:____ Best:____ Worst:____

6. Describe your pain: (check all that apply)

- ☐ Constant
- ☐ Comes and Goes
- ☐ Sharp/Stabbing
- ☐ Burning
- ☐ Dull/Ache
- ☐ Throbbing
- ☐ Numbness/Tingling

7. What makes your symptoms...
Worse:_____
_____
Better:_____
_____

8. What are your therapy goals?

_____
_____

9. What imaging have you received for your problem? (Check all that apply)

- ☐ X-ray
- ☐ MRI
- ☐ CT scan
- ☐ EMG
- ☐ Bone Density Scan

10. Have you experienced any falls in the last year?

- ☐ Yes (if yes, please describe incident briefly below)
  - o _____
    _____
- ☐ No

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Financial Policy:

We at Kempton Physical Therapy are dedicated to providing you with excellent service. We feel that a part of that excellent service is ensuring that you have a good understanding of our financial policy.

Patient Responsibilities:
You must bring in your **current** insurance card. We must make a copy of both the front and the back of your card in order to bill your insurance. It is your responsibility to notify us immediately of any changes in your insurance. If accurate information is not provided for the timely submission of claims, you will be held responsible for the full amount of any charges incurred. We will file your primary insurance and secondary insurance if it is transmitted electronically from your primary insurance company. If you are a Medicare subscriber, we will file your secondary insurance for you.

You will be asked to sign an authorization for your insurance carrier to make payment directly to Kempton Physical Therapy. Any payments sent directly to you should be forwarded to Kempton Physical Therapy immediately along with all of the paperwork from your insurance company, so that your account can be credited.

Your insurance will be billed and if payment is not received within ninety days, you will become responsible for those charges. Should this occur, please contact your insurance company as to the reason for non-payment. Resources are available through your insurance company to help you to understand your coverage. Coverage is verified by Kempton Physical Therapy, but verification **does not guarantee payment**. Please contact your insurance company for clarification of benefits.

Payment Policy:
Co-pays: All co-pays are due at time of service. We will verify your insurance and advise you of the co-pay amount and any restrictions your insurance company has placed on physical therapy. Please contact your insurance for clarification of your co-pay amount.
Liens: We occasionally accept liens for accidents. This is done on a case-by-case basis. This requires a signed lien which includes the date of injury as well as the name and address of your attorney. **Signatures are required by you as well as your attorney. You are responsible for having your attorney sign the lien.** If we accept a lien, we will not file with your insurance company. The lien will be used in lieu of your insurance. We will not accept liens for "co-pays only".
Non-Insured: If you are not paying with insurance, we will require payment in full at time of service.
Balances Due: After we have received payment from your insurance, any remaining balance is due thirty days from the date of the first statement. Interest will accrue at 1.5% for balances over 90 days old. If this matter is referred for collections, the prevailing party shall be entitled to reasonable attorney fees and costs.

_____ _____
Signature Date

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NOTICE TO ALL MEDICARE PARTICIPANTS
2019 PHYSICAL THERAPY/SPEECH GUIDELINES

The moratorium for physical therapy and speech services has expired and the yearly CAP of **$2040.00** has been reinstated as of January 1, 2019. This means, physical therapy and speech therapy combined benefits are available to all Medicare participants at a maximum level of **$2040.00** billed per calendar year.

Note: This CAP does not apply to any therapy rendered at the hospital or in-home therapy.

Kempton Physical Therapy will make every attempt to contain costs as to not exceed your annual Medicare allowance; however some circumstances may prevent us from receiving the necessary information. **Please notify our front desk if you have received any physical therapy or speech therapy in the year 2019.**

This notice is to provide documentation that Kempton Physical Therapy has informed you of the Medicare guidelines for physical therapy for the year 2019.

We apologize for the limit being placed on you and the inconvenience it may cause you. Any further concerns or questions should be directed to our office manager.

PRINT NAME _____ DATE _____

SIGNATURE _____

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