Dear First Time Patient,

Welcome to the "Kabat & Associates" family and thank you for your interest and appointment with us. We look forward to entering with you into a positive and progressive Physical Therapy experience.

Enclosed you will find the necessary paper work that should be completed at the first visit and prior to your evaluation with the Physical Therapist. Please take this opportunity to fill in the paperwork to the best of your ability. Make sure to review each document and sign. Feel free to use our website at kapt4u.com for helpful information. When you arrive for Physical Therapy sessions (including first one), please wear comfortable clothing to be able to exercise in and to easily allow us access to your injury. It will be best to arrive 10-15 minutes before the first appointment (especially if there are any questions with paperwork). Anticipate for your appointments to be about 55 minutes for the first session and follow up appointments, unless informed otherwise. Follow up sessions will be made at the end of the first session.

For your appointment please bring:

- Comfortable clothing
- A pair of most commonly worn shoes (for assessment)
- Payment
- Insurance Card(s)
- Prescription for Physical Therapy in addition to helpful MD, X-ray, MRI and other comparable reports if available
- An open mind to learn something new about yourself.

We look forward to meeting you and working with you towards a positive Physical Therapy experience!

Sincerely,

Kabat & Associates Physical Therapy

"EMBRACE A PIVOTAL MOMENT, EXPLORE YOUR POTENTIAL, ENHANCE THE WORLD"

Please take your time and READ CAREFULLY each section and INITIAL EACH BOX:

1) **Communication:** As a means to optimize patient / therapist experience, patient is encouraged to communicate in such a way that questions and concerns are answered about treatment, insurance, billing, symptom management, home exercises, and overall experience.

2) **Last Minute Cancellations and Not Showing** – $65.00 Fee: See our policy on the next page.

3) **Please be on Time**: See our policy on the next page.

4) **Payments / Co-payments / Co-insurances / No-Show fees**: All payments for Physical Therapy services are due at **EACH** time of service. Services may be paid for by: Cash, Check, or Credit Card .

5) **Proper Clothing**: Many of our therapeutic interventions include specific manual "hands on" treatment and exercise progression. We ask that you wear clothing appropriate to allow access to your injured areas, stretching, and exercises. Shoes must be removed during treatment on certain tables and equipment.

6) **No Cellular Phones and Electronic Devices**: Phone conversations and electronic devices are considered disruptive when in the clinical setting and / or in the company of patients and staff. ***We require that urgent phone calls be taken outside only***. HIPPA / privacy laws and regulations require that no pictures or videos be taken within the building unless given special permission by a Physical Therapist to enhance the immediate treatment.

7) **Family and Friends**: Family, friends, and guests must wait for patient in the waiting room or outside, unless, given permission on a "visit by visit" basis to observe and join in part or all of the treatment session. Children under the age of 18 must have a parent / chaperone remain on site.

8) **Home Exercise Program**: It is expected that patients comply with and attempt to perform the Home Exercise Program (HEP) and symptom management techniques given by the Therapists. The patient acknowledges that the HEP and education provides a valuable contribution to the treatment progression and patient is expected to discuss all questions and comply as directed.

9) **Insurance**: If you choose to use your insurance to pay for services, it is your responsibility to ultimately verify that your insurance will cover our services. As well, you are advised to understand your co-pays, co-insurance, and deductibles if applicable as you strategize the investment in this valuable process. If there is a change in your insurance / coverage, you agree to alert us in our office as soon as you are aware of this. As a courtesy, we may assist you in verifying benefits, but remind you that this is based on information given by your insurance company. Self-pay options are available for some of those who do not choose to use insurance.

10) **Lockers**: Lockers are available for patients to use. You are free to use them at your own discretion as Kabat & Associates Physical Therapy is not responsible for any misplaced, damaged, or lost items. Please be respectful of other's items.

Signature _____

CANCELLATION/NO SHOW POLICY

We have much we plan to accomplish with you on each visit. We reserve quality time appointment spots for each patient as a means of delivering personal and quality care. Not showing for an appointment or cancelling with less than a 24 hour notice eliminates the chance to receive appropriate care and also significantly limits the chance for another patient to have that appointment.

Canceling an Appointment

If you need to cancel an appointment please contact our office via phone **AT LEAST 24 hours prior** to your scheduled appointment date and time to avoid a late cancellation fee.

No Shows and Late Cancellations

Patients who scheduled an appointment and simply **do not show** up or **cancel with less than a 24 hour notice** will be charged a no show/late cancellation fee.

No show or late cancellation fee: $65.00 fee, this will be charged to the patient.

- This is a non-medical agreement, and therefore subject to all patients, including Workers Compensation patients.

Continuous No Shows or Cancellations

If more than 2 "No-Shows" or multiple "cancellations and last minute cancellations" occur, we reserve the option to cancel all future appointments and request a phone conversation between you and your treating Physical Therapist prior to continuing. Your consistent attendance and punctuality is essential to the progression and successful coordination of your care.

Please be on Time

We want you to get the full benefit of your treatment plan. All clinical treatments include a one-on-one approach as part of the session with one of the clinicians. Arriving late compromises your access to the comprehensive treatment planned for the scheduled visit. If you arrive more than 10 minutes late, the office and /or scheduled clinician reserves the option to cancel your daily visit and consider it a no-show.

I understand the no show/cancellation policy and agree to its terms.

Print Name:_____

Signature:_____ Date:_____

General Information:

Name: _____ ***Age:*** _____ ***DOB*** _____ ***Gender: M / F***

Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

Phone: _____ ***e-mail:*** _____

Spouse / Guardian name: _____ ***May we give them your medical information? Yes / No***

Emergency Contact: _____ ***Contact Phone:*** _____

What are we seeing you for? Diagnosis: _____

_____

Who is referring you to our clinic? (MD, self): _____

List other doctors / MDs / health care practitioners in this case: _____

_____

Consent to treat a minor:

I / We being the parent / legal guardian of _____ a minor age of ____ years old, do hereby consent, authorize, and request Kabat & Associates Physical Therapy, Inc. to administer such treatment as deemed advisable, necessary, or requested for the above named minor. I / we agree to hold Kabat & Associates Physical Therapy Inc. free and harmless from any claims, suits, damages or complications which may result from such treatment.

Other than myself, I approve the release of patient records to the following Doctors offices / parents / guardians / people:
List: Medical Office: _____ City: _____ Phone: _____
List: Name: _____, Relationship to patient: _____
Name: _____, Relationship to patient: _____

X _____ _____

Signature of Parent / Legal guardian **Date**

Notice of Privacy Practices - Consent Form: All must sign

By my Signature below, I acknowledge that I have been given the opportunity to review the ***Notice of Privacy Practices*** for Kabat & Associates Physical Therapy.
(The notice is available for viewing on the waiting room wall, on our website at kapt4u.com, and / or for you to take / view in paper form at our front desk).

X _____

Signature of Patient

Health Questionnaire

Please Fill Out Completely **Date:**_____

Name_____ **Age**_____ **DOB** _____

When did your injury / condition occur? _____, Did it begin ◯ immediately or ◯ gradually.

How did it occur? _____

_____

What body parts were initially painful or affected?_____

_____

What body parts are currently painful or affected?_____

_____

Since this condition / injury began, are your symptoms: ◯ Increasing ◯ Decreasing ◯ No change.

How often do you feel your symptoms?
◯ Occasional (10-25%) ◯ Intermittent (26-50%) ◯ Frequent (51-80%) ◯ Constant (90-100%)

If you have pain, please mark your pain on the scale below. "0" is no pain, "10" is worst pain ever.
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Choose what most accurately describes your symptoms.
◯ Symptoms are noticeable but able to perform all activities.
◯ Symptoms are tolerated but may cause difficulty performing some activities.
◯ Symptoms interfere with performance of all activities.
◯ Symptoms are so severe that you are unable to perform any activity.

What is limited or makes your condition feel worse?

◯ Sitting	◯ Standing	◯ Walking	◯ Running	◯ Stairs
◯ Kneeling	◯ Bending at back	◯ Twisting at back	◯ Lifting	◯ Squatting
◯Repeated motion	◯ Bending at neck	◯ Rotating neck	◯ Desk work	◯ Driving
◯Mental stress	◯ Temperature	◯ Coughing	◯ Sneezing	◯ Other

Other: _____

_____

What activities with your *personal / work* lifestyle are <u>difficult</u> as a result of your symptoms / pain:

1	2
3	4
5	6

What makes your condition feel better?

◯ Rest	◯ Position changes	◯ Standing	◯ Hot compress	◯ Medication
◯ Lying Down	◯ Movement	◯ Exercise	◯ Cold Compress	◯ Stretching
◯ Massage	◯ Manipulation	◯ Knowledge	◯ Sleep	◯ Other

Other:_____

Sleep: ◯ Good ◯ Fair ◯ Poor / **Sleep Position**: ◯ Back ◯ Sides R / L ◯ Stomach ◯ Reclined
Average hours of quality sleep_____
Activities performed 3 hours before sleep:_____

What treatment have you already received for this condition?

◯ Massage	◯ Surgery	◯ Counseling / Psyc	◯ X-Ray	◯ CT Scan
◯ Chiropractic	◯ Acupuncture	◯ Pain management	◯ MRI	◯ Bone Scan
◯ Injections	◯ Body Work	◯ Personal Training	◯ Sleep Study	◯ Doctor
◯ Other list:				
Medications for this condition:				

General Health (Please check / explain the categories that relate to your health below):

◯ Good	◯ Asthma	◯ Diabetes	◯ TMJ	◯ Cancer
◯ Autoimmune	◯ Gout	◯ Dizziness	◯ Vertigo	◯ Stroke
◯ Osteoarthritis	◯ Pregnant	◯ Post-Partum	◯ Headaches	◯ Short Breath SOB
◯ Rheumatoid Arth	◯ Hernia	◯ Implants	◯ Depression	◯ Vision
◯ Osteoporosis	◯ Digestive	◯ Pacemaker	◯ Bowell difficulty	◯ Bladder Difficulty
◯ Neurological	◯ Painful cycle	◯ Brain Trauma	◯ Concussions	◯ Hearing
◯ Sleep Apnea	◯ Sleep Disturbed	◯ Hormone	◯ Dental	◯ Other

Descriptions of above conditions and others:_____

_____

Heart / Respiratory (Describe): _____

_____

Previous Injuries: _____

_____

All Previous Surgeries:_____

_____

What assistive / adaptive equipment do you use:_____

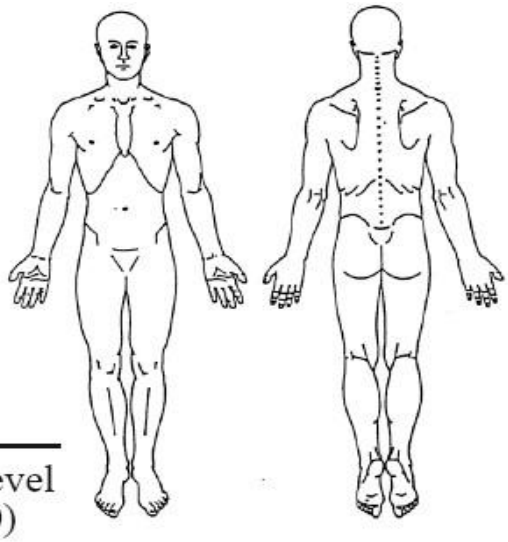
_____

Other Thoughts:_____

Pain/Symptoms

On the Body Diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning



_____
Pain Level
(0-10)

Medications for other conditions

◯ List Provided	1	2	3	4
5	6	7 .	8	9

Approximately how many glasses of water do you drink per day: _____ **Caffeine** Y / N **Smoke** Y / N

Do you have a regular exercise routine? Y / N Describe: _____

_____

Recreational Activities: _____

_____

Are you working? ◯ **Yes /** ◯ **No > Reason:** ◯ **Retired** ◯ **Injury** ◯ **Disability** ◯ **Leave of Absence**
Physical demands specific to your work: _____

_____

Goals with this Physical Therapy experience:

◯ Increase strength	◯ Knowledge	◯ Posture	◯ Symptom control	◯ Exercise
◯ Decrease pain	◯ Body Awareness	◯ Sleep Quality	◯ Balance	◯ Less stress
◯ Other List:				
What activities would you like to perform better:				

Signature:_____ Print Name:_____

Please use this page to get the most out of your session.

Questions to ask my Physical Therapist and the Kabat PT team:

1)

2)

3)

4)

5)

Things I learned during my session:

1)

2)

3)

4)

5)

Exercises I learned during my session:

1)

2)

3)

4)

5)

Additional notes:

Kabat & Associates Physical Therapy, Inc. - Statement of Privacy Notice
- For reference only -
Please refer to this document when signing the "Patient Intake Form"

Effective June 1, 2003

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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (925) 522-8000. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (925) 522-8000. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature on the "**Privacy Practices Notice**" section under the "Policies" form, I provide Kabat & Associates Physical Therapy, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.