Kirk Integrative Physical Therapy

16618 W 159th St, Suite 401 & 402, Lockport, IL 60441
Phone: **(815) 838-0529** ❖ Fax: **(815) 838-0652**
Website: **kc4hl.com**

# Patient Intake Form

Name: ________________________________________ Referral Date: _______________ Height: __________ Weight: __________

Address: ____________________________________________ City: _______________________ State & Zip: ____________________

Home Phone: ________________________ Cell Phone: ________________________ Work Phone: ________________________

Date of Birth: _________________ E-mail: ___________________________________________________

In case of emergency, contact: __________________________________________ Phone: ________________________

How did you hear about us: __________________________________________________________________________________________

Have you received any home health care within the past six months? YES_____ NO_____

Referring Physician: ____________________________________ City: _____________________ Phone: ________________________

Is there someone else that you would like us to send this information to?

Physician: ________________________________________ City: _____________________ Phone: ________________________

Diagnosis / Complaint: ____________________________________________________________________________________

## *RESPONSIBLE PARTY / PARENT / LEGAL GUARDIAN (if applicable)*

Name: ________________________________________________________ Relationship: _________________________________

Date of Birth: _________________ Phone: ____________________________

Address: ____________________________________________ City: _____________________ State & Zip: ____________________

## *EMPLOYER INFORMATION*

Employer Name: _____________________________________________ Occupation: _________________________________________

Address: ____________________________________________________________________________________________________

Phone: ___________________________ Contact Person: __________________________ Attorney: ___________________________

## *PAST SURGERIES*

Description: _____________________________________________________________________________ Date: _________________

Description: _____________________________________________________________________________ Date: _________________

Description: _____________________________________________________________________________ Date: _________________

Description: _____________________________________________________________________________ Date: _________________

## *PAST CONDITIONS / DISEASES / INJURIES / INFECTIONS*

Description: _____________________________________________________________________________ Date: _________________

Description: _____________________________________________________________________________ Date: _________________

Description: _____________________________________________________________________________ Date: _________________

Description: _____________________________________________________________________________ Date: _________________

## *OTHER INFORMATION*

Allergies: __________________________________________________________________________________________________

Date of last pelvic / prostate exam: _________________ Results: ________________________________________________________

Date of last mammogram: _________________ Results: ______________________________________________________________

Date of last dexascan / bone density test: _________________ Results: ____________________________________________________

Date and results of any other recent tests: __________________________________________________________________________

Activity level / work / hobbies: __________________________________________________________________________________

Severity of this condition (0=NO PROBLEMS – 10=UNBEARABLE): _____________________

Your goal from therapy: ___________________________________________________________________________________

______________________________________________________________________________________________________

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# PATIENT SERVICES AGREEMENT

**PATIENT NAME:** ________________________________

**RELEASE OF INFORMATION:** I authorize Kirk Integrative Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance purposes.

**PERMISSION FOR MESSAGES:** I authorize Kirk Integrative Physical Therapy to leave messages -

About my treatment:

- ☐ on my voicemail or answering machine at my home
- ☐ on my voicemail on my cell phone
- ☐ on my voicemail at my work
- ☐ with another person

About my appointment times:

- ☐ on my voicemail or answering machine at my home
- ☐ on my voicemail on my cell phone
- ☐ on my voicemail at my work
- ☐ with another person

*I have read this agreement and understand my obligations*

________________________________ ________________
Patient Signature Date

________________________________ ________________
Patient Address Preferred Phone

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# DOCUMENTATION OF CURRENT MEDICATIONS

Use the below grid to document your current list of medications. This list ***must*** include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration (oral, topical, suppository, inhalant, intravenous).

| ***Medication / Supplement*** | ***Dosage*** | ***Frequency*** | ***Route of Administration*** |
|---|---|---|---|
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**I do hereby attest that this information is true, accurate and complete to the best of my knowledge.**

___________________________________________ ________________

*Patient/Guardian Signature* *Date*

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**I have reviewed the above current medication list with the patient/guardian and it is to the best of my knowledge accurate as of the below signed date.**

___________________________________________ ________________

*Physical Therapist Signature* *Date*

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# CREDIT CARD AUTHORIZATION – (OPTIONAL)

I authorize Kirk Integrative Physical Therapy, PC, to bill the following credit card for services or missed appointments. I understand that if my credit card is declined, a $50.00 fee will be posted to my account.

_____________________________________________
Name of Patient

This authorization is to remain in effect until I cancel it in writing.

The payments I am authorizing are:

- ☐ Account delinquency of 75 days
- ☐ Monthly balance billing
- ☐ Each Visit

For your convenience we accept personal checks, **Visa**, **MasterCard, Discover and Amex**.

| Card Type | Card Number | Expiration Date | CVV Code |
|---|---|---|---|
| **Visa** | | | |
| **MasterCard** | | | |
| **Discover** | | | |
| **Amex** | | | |

Name as it appears on the card: ___________________________________________

Authorized Patient/Guardian/Cardholder's Signature: ______________________________

Billing address on file with credit card:

Street Address: ____________________________________________

City / State / Zip: __________________________________________

Date: _________________

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# Cancellations and No-shows Policy

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

***Cancellations***

- We require 24 hours' notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind, preferably in the same week, that will ensure you get in the full prescribed number of treatments.

***No-shows***

- A no-show is a missed appointment without notice.

***Charges***

Any cancellation less than 24 hours' notice or no-show will be charged as the following:

- Adult evaluation of 1.5 hours: $240
- Adult treatment session of 1 hour: $165
- Adult treatment session of 1.5 hours: $240
- Adult treatment session of 2 hours: $315
- Child evaluation of 1 hour: $165
- Child treatment session of 30 minutes: $90

Full payment of the above charge is due at your next scheduled appointment.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Thank you for cooperating with us in this regard. We are looking forward to working with you.

______________________________ ______________________

Patient/Guardian Signature Date

______________________________ ______________________

Interviewer Signature Date