Kelsar Physical Therapy

Main Office: 606 West Main Street, Norwich, Ct 06360
Satellite Office: 107 Wilcox Rd., Suite 104, Stonington, Ct 06378
Phone: 860-886-2042 Fax # 860-885-1811

Full Name: _____ Date of Birth: _____ SS#: _____

Address: _____ Circle One: Married/Single/Widow/Child/Divorced/Other

_____ Phone #: (Home) _____

Employer's Name: _____ (Work) _____

Address: _____ (Cell) _____

_____ Emergency Contact: _____

Occupation: _____ Relationship & Phone #: _____

Primary Insurance: _____ Secondary Ins. (If Applicable): _____

ID#: _____ ID#: _____

Subscriber Name: _____ **Subscriber Name**: _____

Relationship to Subscriber: _____ Relationship to Subscriber: _____

Subscriber DOB: _____ **Subscriber DOB**: _____

Subscriber Employer: _____ Subscriber Employer: _____

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

Circle one if Applicable: Workers' Compensation/Auto Insurance

Insurance Company Name: _____ Claim#:_____DOI: _____

Contact Person: _____ Phone: _____ Fax: _____

Attorney: _____ Phone: _____

Knowing your Insurance coverage is your responsibility. We are not responsible for incorrect information provided to us by your insurance carrier. **Payment is due** at the time of service including deductibles, co-pays, percentage of responsibility, and any costs not covered by your insurance carrier. You must notify Kelsar Physical Therapy staff of changes in your insurance participation, or referring physician. **Billing:** We bill electronically for most insurance companies.
Cancellation Notice: 24 hours is appreciated: A 24 hour voicemail system is in use. We reserve the right to bill or charge you $50.00 for appointments missed, last minute cancellations and not shows. If you miss more than two appointments with your therapist they have the right to have you removed from their schedule. If you miss more than two appointments without notice all further appointments will be cancelled and you will be discharged from the practice. We will notify both you referring doctor and insurance company of your noncompliance with our program.
Confidentiality Policy: I understand that as a patient of Kelsar PT, I will not discuss any information on any patient and/or client, either verbal or written, of the establishment unless written approval/consent is obtained from said person.

Having read the above information, I am aware of my responsibilities and agree to the policies of Kelsar Physical Therapy and authorize Kelsar Physical Therapy to furnish full details of my medical case to my physicians and insurance company. I give Kelsar PT permission to obtain any reports from another facility needed for my treatment plan.

Signature: _____ Date: _____

If under the age of 18, parent/guardian: _____

YOUR APPT. IS SCHED. FOR _____ @ _____ IN THE NORWICH/STONINGTON OFFICE. PLEASE BRING THIS PAPERWORK, PRESCRIPTION, INSURANCE

Medical History

Current condition for which you are receiving physical therapy: _____
_____
When did your symptoms begin? _____

Check any of the conditions below that you currently have or have had in the past 12 months:

___Allergies/Hay Fever	___Asthma	___Bladder Infections
___Breathing Difficulty	___Chest Pain	___COPD
___Concussion/Head Trauma	___Thyroid Dysfunction	___Swallowing Difficulty
___Dizziness/BPPV	___Phlebitis	___HIV/AIDS
___Epilepsy	___Fatigue	___Gastrointestinal Problems
___Headaches/Migraines	___Heart Disease	___Hepatitis/Jaundice
___Hot/Cold Intolerance	___Lyme Disease	___Osteoporosis/Osteopenia
___Kidney Disease	___Pacemaker	___Edema (generalized swelling)
___Diabetes: controlled/uncontrolled		___Hernia
___High Blood Pressure: controlled/uncontrolled		___Gastric Bypass Surgery
___Unexplained sudden weight gain or loss		___Lap band Surgery

___Psychiatric Disorder: _____
___Skin Disorder: _____
___Vascular Condition: _____
___Childhood Orthopedic Conditions: _____
___Latex or other contact allergy: _____
___Metal Implants or Hardware: _____
___Cancer: Where? _____ In remission? _____
___Other: _____

Height: _____ Weight: _____

Your level of pain or discomfort: (0 = none, 10 = "Take me to the hospital immediately!")
Best: _____ Worst: _____ Average: _____

Are you or could you be pregnant: Yes or No

Please describe any surgical procedures or hospitalizations you have had in the past year (or pertaining to your current condition), including the dates:

_____
_____
_____

Please describe any medications or supplements you are taking, including dosage:

_____
_____
_____

Are you presently involved in an exercise program or have been in the past? Yes or No
Have you consulted other health professions for your current problem? Please Identify and Dates:

Have you been treated for this condition in the past? If yes, when:

_____

_____

List the goals you would like to accomplish through physical therapy:

_____

_____

IF YOU NEED ANY FURTHER INFORMATION REGARDING OUR FACILITY INCLUDING DIRECTIONS PLEASE VISIT OUR WEBSITE: **www.kelsarphysicaltherapy.com**

How did you hear about Kelsar Physical Therapy? _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notices of Privacy Practices and I have been provided an opportunity to review it.

NAME: _____ BIRTHDATE: _____

SIGNATURE: _____ DATE: _____

A COPY OF THE HIPPA NOTICE IS AVAILABLE FOR YOU AT REQUEST.

I _____ GIVE KELSAR PHYSICAL THERAPY PERMISSION TO LEAVE A MESSAGE ON MY VOICEMAIL/MACHINE TO CONFIRM APPOINTMENTS AND REGARDING MY INSURANCE/BILLING.

SIGNATURE: _____ DATE: _____

I _____ GIVE KELSAR PHYSICAL THERAPY PERMISSION TO DISCUSS MY TREATMENT WITH THE FOLLOWING:

PRIMARY CARE PHYSICIAN: _____ DATE: _____

PERSON'S NAME: _____ RELATIONSHIP: _____

PERSON'S NAME: _____ RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____