KORT New Patient Information

Patient Name:_____ E-Mail Address: _____

Address:_____City/State/Zip: _____

Date of Birth:____/____/____ Age:_____ Sex: _____ Social Security Number:_____-_____-_____

Marital Status:_____Home Phone:_____Cell phone: _____

Employer/School: _____ Occupation: _____

Employer Address:_____Work Phone Number: _____

Spouse (or parent, if minor):_____Phone Number: _____

Spouse or Parent Employer:_____ Address:_____

Contact person outside of home:_____Phone No.: _____

Referring Physician:_____Primary Care Physician:_____

If Minor Child, name of Guarantor:_____Relationship: _____

Address if different than above: _____

Onset Date (injury, accident, or recent date symptoms started):___/____/____did you have Surgery? ☐Y ☐N Date:____/____/____

Was this injury the result of a Motor Vehicle Accident?☐ Work related injury ☐ ***(if Yes please provide injury date above)***

W/C or MVA Insurance Company _____ Adjuster Name _____Claim # _____

Medical Health Ins. Co. _____ ID # _____ Policy Holder _____

Would you like appointment reminders:☐Y ☐ N: If yes, would you like them by: **Phone** ☐ **Email** ☐ **Text** ☐

How did you hear about us? Family/Friend ☐ **TV/Radio** ☐ **Referral** ☐ **Internet** ☐ **Other** ☐

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize KORT to disclose my health information that is directly related to my current treatment at KORT to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signature: _____relationship to patient: self – guardian – other) **Date:** _____

KORT
The Best In Rehab.

Consent to Treatment; Authorization to Release Information; and Statement of Financial Responsibility

Revised 06/01/2018

Patient Name:_____ **Date**:_____ **Acct#**:_____

KORT appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or you may access our on-line bill payment option @ https://KORT.com once a statement is received from the billing office, or by calling our customer service department at 1-855-716-6412.

I have read the above policy regarding my financial responsibility to KORT for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to KORT. I agree to pay KORT the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Patient Service Specialist Initials: _____

Signature: _____(relationship to patient: self – guardian – other:_____) **Date:**_____

You agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and use of automatic dialing devices, as applicable.

Signature: _____(relationship to patient: self – guardian – other:_____) **Date:**_____

You will receive calls and/or text messages that deliver autodialed or pre-recorded telemarketing messages from an automatic telephone dialing system. You consent to receive such calls and/or texts at the telephone number associated with your account. Your consent to receive such calls and/or text messages is not a condition of any purchase of a service or product.
I/We have read this disclosure and agree that Provider, and/or their representative, may contact me/us as described above.

Signature: _____(relationship to patient: self – guardian – other:_____) **Date:**_____

I acknowledge that the Notice of Privacy Practices and Notice for Federal Civil Rights is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature: _____(relationship to patient: self - guardian - other: _____) **Date:**_____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I am aware of my diagnosis and voluntarily consent to have KORT, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical, speech, and occupational therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from KORT is limited to physical, speech, and/or occupational therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature: _____(relationship to patient: self - guardian - other: _____) **Date:** _____

I further authorize KORT to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____(relationship to patient: self - guardian - other: _____) **Date:**_____

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Medicare Secondary Payor
(MSP) Questionnaire – Page 1

PSS Name: _____
Facility Phone: _____
Person Contacted @ HHA:
Name: _____ Phone: _____
Discharged? Y☐ N☐ Discharge Date: _____
IF QUESTION 1= YES—FAX FORM TO 717-412-9818

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Office use only

Patient Name: _____
Medicare Number: _____
(exactly as appears- Red-White-Blue Government Medicare Card)

Clinic Name: _____
Patient Acct#: _____
Database: _____

1. **Have you received Home Health Care of any kind in the past 60 days or currently are residing in a Skilled Nursing Facility?** ..... **Yes☐ No☐**
   Agency Name/Facility Name: _____
   Phone: _____
   If in a Skilled Nursing Facility: **Are you on/in the "Medicare Unit"?** Yes☐ No☐

2. **Are you entitled to benefits under the Black Lung Program, Dept. of Veteran Affairs or other government program?** ..... **Yes☐ No☐**
   If yes, Program Name: _____ Phone: _____
   Address, City, State, ZIP:
   _____
   NOTE: *The government program listed in question #2 will be primary to Medicare.*

3. **Was this injury/illness due to any of the following?**
   Work-related? **If yes**, date of accident/injury: _____ /_____ /_____..... **Yes☐ No☐**
   Auto accident? **If yes**, date of accident: _____ /_____ /_____ ..... **Yes☐ No☐**
   Accident on Property? (other than your own)(Example: store, restaurant, etc.) ..... **Yes☐ No☐**
   If yes, date of accident: _____ /_____ /_____
   If yes, please give details of the accident:

   If yes, please provide the following information about the **liability insurance**:
   Insurance Name: _____ Phone: _____
   Address, City, State, ZIP:
   _____
   Contact Person/Adjustor's Name: _____
   Claim Number: _____ (**required**)
   NOTE: *Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing with Medicare. Your understanding and cooperation is appreciated.*

4. **Do you feel you have a right to be compensated by a party who may have caused the injury or illness?** ..... **Yes☐ No☐**
   If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness? ..... Yes☐ No☐
   If yes, Attorney's Name: _____
   Law Firm Name: _____
   Address: _____
   Phone number: _____

(Page 1 of 2 – Go to Page 2)

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Medicare Secondary Payor (MSP) Questionnaire – Page 2

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Office use only

Patient Name: _____ **Clinic Name:** _____

Medicare Number: _____ **Patient Acct#:** _____

(exactly as displayed on Red-White-Blue Government Medicare Card) **Database:** _____

5. Have you received a kidney transplant or are currently receiving dialysis for End Stage Renal Disease (ESRD)? ..... **Yes** ☐ **No** ☐

If yes, please provide the date of the transplant or start of dialysis: ____/____/____

If the date is less than 30 months ago: **Are you currently covered under group insurance provided by your or a family member's employer?** Yes ☐ No ☐

If yes – the group insurance will be primary **If no** – Medicare will be primary

6. Are you currently employed? ..... **Yes** ☐ **No** ☐

If yes, Does your employer employ more than 20 employees? ..... Yes ☐ No ☐

If no, Date of retirement:_____/_____/_____ or check ☐ Not employed

Is your spouse currently employed? ..... **Yes** ☐ **No** ☐

If yes, Does his/her employer employ more than 20 employees?..... Yes ☐ No ☐

If no, Date of retirement:_____/_____/_____ or check ☐ Not employed

(NOTE: If both are not currently employed, then Medicare is primary.)

7. If you've answered No to questions 1 – 6 AND your Medicare coverage is due to age or disability:

Do you have a group insurance plan through another family member's current employer? ..... **Yes** ☐ **No** ☐

If yes – the group insurance will be primary **If no** – Medicare will be primary

Do you have any benefits through TriCare (formerly Champus)? ..... **Yes** ☐ **No** ☐

8. If you answered YES to questions 6 or 7, please complete the following group insurance information for the proper billing of your account:

Insurance Co. Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Employer Name: _____

Insured's Name: _____

Policy Identification Number: _____ *(Sometimes referred to as the health insurance benefit package number.)*

Group Identification Number: _____

Patient signature _____ Date _____

Appointed Representative signature _____ Relationship _____

(Page 2 of 2 – END OF QUESTIONNAIRE)

Rev. 3/2011

Medical Screening Form

KORT
The Best In Rehab.

Name:_____ Date:_____

Please circle YES or NO

Do You Have A History Of:	SELF	FAMILY
Diabetes?	Yes No	Yes No
High Blood Pressure?	Yes No	Yes No
Heart Attack?	Yes No	Yes No
Heart Disease?	Yes No	Yes No
High Blood Cholesterol?	Yes No	Yes No
Smoking?	Yes No	Yes No
Chest Pain?	Yes No	Yes No
Dizziness/Fainting?	Yes No	
Shortness of Breath?	Yes No	
Ankle Swelling?	Yes No	
Night Coughing?	Yes No	
Stroke?	Yes No	Yes No
Cancer?	Yes No	Yes No
Osteoporosis?	Yes No	Yes No
Osteoarthritis?	Yes No	Yes No
Rheumatoid Arthritis?	Yes No	Yes No
Rheumatic Disease?	Yes No	Yes No
Alcohol Use?	Yes No	
↳Current number drinks/week?	_____	
Allergies?	Yes No	
↳Type?	_____	
Asthma?	Yes No	
↳Always have inhaler with you?	Yes No	
Childhood Diseases?	Yes No	
Falling?	Yes No	
↳Number of times in last year?	_____	
Headaches?	Yes No	
Kidney Disease?	Yes No	
Lung Disease?	Yes No	
STDs?	Yes No	
Seizures?	Yes No	
Pacemaker/Defibrillator?	Yes No	
Assistive Device (e.g. cane)?	Yes No	

In the Past 3 Months, Have You Experienced:

Unexplained change in your health? Yes No
↳If yes, please describe:
_____

Explained illness or injury? Yes No
↳If yes, please describe:
_____

Unexplained weight change? Yes No
Night sweats? Yes No
Fever? Yes No
Numbness or tingling? Yes No
Changes or difficulty with bowel? Yes No
Changes or difficulty with bladder? Yes No

In the past month, have you frequently been bothered by feeling down, depressed or hopeless? ..... Yes No

In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things? ..... Yes No

Do you have a problem with… (check all that apply)

☐ Hearing ☐ Speech
☐ Vision ☐ Communication

Do you regularly exercise? ..... Yes No
Number of days per week? _____
Number of minutes per session? _____

What is your body weight? _____ height? _____

Please list any medicine allergies you may have:
_____
_____

Are you allergic to Latex? Yes No Adhesives? Yes No

Please list or provide a copy of the medications you are currently taking: (Dosages not necessary)
_____
_____
_____

Please list any major surgeries in your past:
_____
_____
_____
_____

Other:
_____
_____
_____
_____
_____

Women:

Are you or could you be pregnant? ..... Yes No

Patient/Representative Signature:_____ Therapist Signature: _____

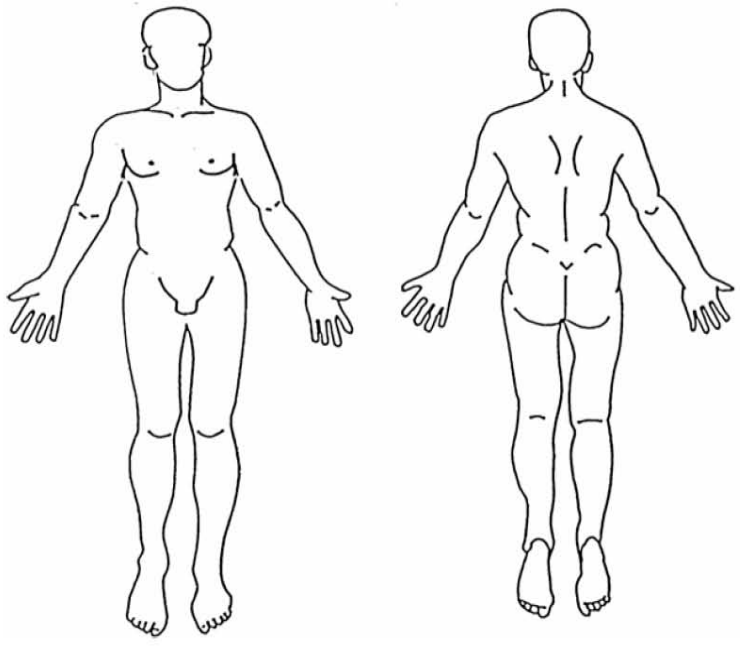
Medical Screening Form – Page 2

Name:_____ Date:_____

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = oooooooo Stabbing = //////////
Burning = XXXXXX Deep Ache = ZZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain or symptom on the following line:

_____

0 1 2 3 4 5 6 7 8 9 10

(**0** = none → **10** = worst imaginable. Indicate level for each with B, C, and W)

What makes your pain or symptom worse?

_____

What makes your pain or symptom better?

_____

Are your symptoms: (check one)
☐Getting worse ☐The same ☐Improving

How are you able to sleep at night? (check one)
☐Fine ☐Moderate Difficulty ☐Only with Medication

Do you have pain at night? Yes☐ No☐

When (date) did your problem begin? _____

Have you been treated for this before? Yes☐ No☐
When? How?_____

PATIENT SPECIFIC FUNCTIONAL SCALE

Please list three (3) activities that you are having difficulty performing. Please rate your ability next to each activity

(**0** = unable to perform → **10** = can perform normally)

1. _____ _____
   0 1 2 3 4 5 6 7 8 9 10
2. _____ _____
   0 1 2 3 4 5 6 7 8 9 10
3. _____ _____
   0 1 2 3 4 5 6 7 8 9 10

Other Relevant Information?_____

_____

_____

_____

Patient or Representative Signature:_____ Date:_____

Reviewer Signature/Initials:_____ Date:_____