



First Name: _____ Middle Initial: _____ Last: _____

Gender: Male Female Date of Birth: _____ Marital Status: S M D W

Address: _____ City: _____ Zip: _____

Primary Phone# _____ Secondary# _____

(Please circle one) Home Cell Work Home Cell Work

Emergency Contact: _____ Relationship: _____ Ph#: _____

Referring Physician: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber's Name: _____

ID#: _____ Group#: _____ Subscriber's DOB: _____

Secondary Insurance: _____ Subscriber's Name: _____

ID#: _____ Group#: _____ Subscriber's DOB: _____

Email: _____

Is this Work Related? YES NO Auto Related? YES NO (Complete below if YES)

Name & Address of Employer: _____

Phone: (_____) _____ Fax: (_____) _____

Adjusters Name: _____ Ph# _____ Claim# _____

Name & Address of Insurance Co: _____

Do you have an Attorney? YES NO Attorney Name: _____

Ph# (_____) _____ Ext: _____ Fax#: (_____) _____

Address: _____ City: _____ Zip: _____

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____

(If patient is a minor)



Patient Name: _____ Today's Date: _____

How did you hear about us? Physician's Office Friend/Neighbor Website/Facebook
 Other _____

1. Is this injury related to: Work Car Accident Other Potential Liability/Potential Lawsuit NA
2. Do you have a Primary Care Physician/Family Doctor? YES NO
 If yes, have you had an appointment with him/her in the last 1 month? YES NO
3. Race/Ethnicity:
 African American Native American Caucasian (White) Latino or Hispanic
 Other _____ Declined

If you are a Medicare beneficiary, you are required by Medicare to answer question 4:

4. Do you consume more than 7 alcoholic drinks in a week? YES NO
5. Please mark boxes below as appropriate:

Please Mark One Box For Each Item	No	>1 year	<1 Year	Please Mark One Box For Each Item	No	>1 year	<1 year
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Vascular Accident (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Degenerative Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus Type 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus Type 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Faintness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fracture or Suspected Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other..... (See Below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify if you have checked "Other" above: _____

Do you have Allergies? YES or NO Please specify _____

MEDICATION LIST

Patient Name: _____

Today's Date: _____

(Please check one box below)

Not currently taking any medications

Currently taking medications, please list below:

Drug Name	Dosage	Frequency (how many & how often)	Route of Administration (oral or injection)

MEDICARE PATIENTS ONLY:

Therapy Services:

Have you had **ANY** therapy services elsewhere this year? Yes No

If Yes, when? _____

Have you been discharged? Yes No

Home Health:

Is anyone coming to your home to provide healthcare services? Yes No

Nurse Home Health Aide Therapy Services

If Yes, when? _____

Have you been discharged? Yes No

Notice & Consent to Treat

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of Notice of Privacy Practices which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how Kiwi PT may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (248) 724-4400.

X _____
Patient or Guardian Signature

X _____
Date

Kiwi PT reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administration and copying fee paid to *Kiwi PT* before they are released, regardless of requestor. *Kiwi PT* is HIPAA compliant with regard to your information.

CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS

I hereby authorize *Kiwi PT*, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician in the treatment of my condition. I further authorize *Kiwi PT* to furnish the appropriate agencies, for the purpose of billing, any information *Kiwi PT* acquired during the course of my treatment. I am assigning payments to *Kiwi PT* on my behalf.

By signing this document, I acknowledge that I have read, understand and agree that the information *Kiwi PT* contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable, any information *Kiwi PT* used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

I further understand and acknowledge that *Kiwi PT* may lease or license real estate, equipment or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I consider *Kiwi PT* of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns releases and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releases") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Lease Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releases or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law.

X _____
Signature of Responsible Party

X _____
Date