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	□	□	□	Muscular Dystrophy	□	□	□
Cardiovascular Disease	□	□	□	Multiple Sclerosis	□	□	□
Cerebral Vascular Accident (Stroke)	□	□	□	Numbness/tingling	□	□	□
Current Infection	□	□	□	Obesity	□	□	□
Degenerative Joint Disease	□	□	□	Osteoarthritis	□	□	□
Diabetes Mellitus Type 1	□	□	□	Osteoporosis	□	□	□
Diabetes Mellitus Type 2	□	□	□	Pace Maker	□	□	□
Dizziness/Faintness	□	□	□	Parkinson's	□	□	□
Fibromyalgia	□	□	□	Peripheral Neuropathy	□	□	□
Fracture or Suspected Fracture	□	□	□	Rheumatoid Arthritis	□	□	□
High Blood Pressure	□	□	□	Seizures	□	□	□
History of Cancer	□	□	□	Spinal Cord Injury	□	□	□
Immunosuppression				Skin Disease	□	□	□
Lupus	□	□	□	Traumatic Brain Injury	□	□	□
Metal Implants	□	□	□	Other…….. (See Below)	□	□	□

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 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) 387-5494.

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* acquires 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 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 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 assign releases and forever discharge any and all direct or beneficial owners of the Leased Property (Building) 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.

Patient or Guardian: ____ Date: _____________________