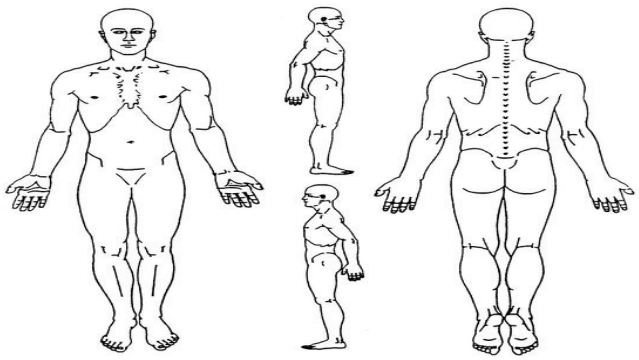
Dear Patient,

We wanted to take this opportunity to personally thank you for choosing Kinetik Performance and Rehab as your physical therapy provider. Below this paragraph are a few documents to help us get to know you better and provide you with the best possible care. Please provide us with your email and phone number accurately, as this is how we will contact you for future appointments and reminders. Please answer each question to the best of your ability and we will gladly assist you with any sections left blank. Thank you.

Patient Information			
Full Name:	Date of Birth:	Gender:	
Email Address:			
Address:	City:	State:	Zip:
Mobile Phone:	Home Phone:		
SSN (billing purposes only):	Marital Status:		
Emergency Contact:	Relation:	Phone Number:	
Employer Information			
Employer Name:	Occupation:		
Employee Status:		Employer Phone:	
☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Light Duty			
Patient is a minor			
Name of Guarantor:	Relationship:	Phone:	
Guarantor Address:	City:	State:	Zip:

KinetiK Physical Therapy, Inc.
DBA Kinetik Performance and Rehab
Address: 23382 Madero, Suite A ● Mission Viejo, CA 92691
Phone: 949.464.4009 ● Email: kinetikpar@gmail.com ● www.kinetikpar.com

Medical History Questionnaire			
Height:	Weight:	BMI:	Age:
ft. inches	lbs.		
Injury Location (Please check one):			
☐ Home ☐ Work ☐ Auto ☐ Sport ☐ Other			
What is the reason for your visit? If more than one, please notate in order of importance.			
Describe how symptoms began:			Date of onset:
Date of surgery:	Type of surgery:		
Have you received physical therapy for this problem before?		If yes, when and where?	
☐ Yes ☐ No			
Please indicate the location of your pain on this chart:		How do you describe your pain?	
		☐ Aching ☐ Numbness ☐ Pins and Needles ☐ Burning ☐ Stabbing ☐ Dull ☐ Other_____	
Rate the intensity of your pain 0-10 (0 = no pain, 10 = "Put me out of my misery!"):			
Pain at Best			
Pain at Worst			
Pain Today			

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In the last 30 days, have you received services from a hospital, nursing home, or home health agency? If yes, when and from who?	
Yes/No	

Have you had any imaging done for this problem? Please include all relevant images:		
Type	Date Observed	Results
X-ray		
CT scan		
MRI		
Other		

Please list all medications you are currently taking (if unable to fit, please provide medication list):		
Medication Name	Dosage	Frequency

Please list any additional surgeries or treatments you may have received:	
Surgery/Treatment:	Date:

Please check/circle any that apply to you currently or in the past:

Hypertension	Hypotension	Heart attack	Heart disease
Metal implants	Lymphedema	Diabetes	Neuropathy
Vision problems	Concussions	Infections	Pacemaker
Smoker	Hearing problems	HIV	COVID-19
Pregnant	Headaches	Stroke	Seizure
Asthma	Anxiety	Depression	Hernia
Balance issues	Breathing problems	Swelling	Cancer (type?)

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What was your normal level of activity prior to your injury?	
What makes your pain better?	What makes your pain worse?
Please list any questions/concerns you have:	

***Please attach all medical records, medication lists, op reports, MD prescriptions if possible.**

The above Information is correct to the best of my knowledge:

Patient Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____

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COVID-19 Risk and Liability

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I and/or my family may be exposed to or infected by COVID-19 by attending Kinetik Performance and Rehab (Kinetik PaR) and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Kinetik PaR may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Kinetik PaR employees, volunteers, and program participants and their families. I voluntarily agree to assume all the foregoing risks and accept sole responsibility for any injury to my family or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my family may experience or incur in connection with my attendance at Kinetik PaR or participation in Kinetik PaR programming ("Claims"). I hereby release, covenant not to sue, discharge, and hold harmless Kinetik PaR, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Kinetik PaR, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any Kinetik PaR program.

Patient Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____

Patient Consent to Treatment

I hereby consent to the therapeutic procedures outlined and to be performed by Kinetik Performance and Rehab and their associates. I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain. I understand that therapeutic procedures can include but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as: heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping and neuromuscular electrical stimulation. I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time. I understand that I may consult with other therapists and/or physicians at any time regarding my condition. I understand that no guarantee of a successful outcome has been given to me. I understand to inform my therapist of any change in condition throughout my care.

Patient Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____

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Cancellation and No-Show Policy

Here at Kinetik Performance and Rehab (Kinetik PaR), we are committed to your success. For best results, it is imperative that you attend your scheduled visits. Consistent attendance allows the provider to progress your treatment and results in faster recovery. It is required to notify Kinetik PaR at least 24 hours in advance of a cancellation or reschedule. **In the event of a late cancellation or no show, a $50 fee will be issued towards the patient's balance**. These fees are not covered by insurance. If you need to cancel, please call or email our front desk 24 hours prior to your appointment time.

Patient Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____

Photo and Video Release (optional)

I hereby authorize Kinetik Performance and Rehab (Kinetik PaR) to use my testimonial, photos, videos, audio and any information contained herein, in its media, public relations, marketing, social media, and educational efforts. I understand and approve the disclosure of the testimonial, photo, video, or audio information to the media and other individuals and entities that may be involved in these efforts for Kinetik PaR.

I authorize Kinetik PaR to disclose limited information about my condition or treatment for these purposes and understand that no other protected information will be disclosed publicly, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release Kinetik PaR from any and all claims for damages of any kind based on the use of my testimonial, picture, video, audio or information in the testimonial. By signing below, I agree and acknowledge that I have read and understood the above release and agree to all terms described.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. FOR MORE DETAILED INFORMATION, PLEASE REQUEST A PRINTOUT.

Understand your health record and information:

When receiving physical therapy services from Kinetik Performance and Rehab, a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation, and your treatment plan. It also contains daily treatment notes and progress notes that may be sent to other healthcare providers, affiliates, and Kinetik PaR's business associates such as billing, front office, and ancillary staff.

Patient's rights:
As a patient of Kinetik Performance and Rehab, you have the right to request special privacy protections, request confidential communications, inspect, and copy, amend or supplement, and the right to disclosures. For a detailed description of each, please request a printout.

Concerns and complaints:
If you are unsatisfied with how our office has handled your complaint, please submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services 90 7th Street, Suite 4-100 San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Patient Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____

Arbitration

Any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Orange County, California, before one arbitrator. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such a party's own benefit. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. Allocation of Fees and Costs: The arbitrator may, in the Award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.
BY SIGNING THIS AGREEMENT, YOU ARE AGREEING TO HAVE ANY ISSUE RELATING TO THIS AGREEMENT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Patient Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____