

# 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 dates 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:** \_\_\_\_\_



**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:** \_\_\_\_\_



**Medicare Secondary Payor  
(MSP) Questionnaire – Page 1**

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

**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?** **Yes No**  
 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: \_\_\_\_\_



# 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: \_\_\_\_\_

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**Patient signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Appointed Representative signature \_\_\_\_\_ Relationship \_\_\_\_\_  
**(Page 2 of 2 – END OF QUESTIONNAIRE)**



# Medical Screening Form

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

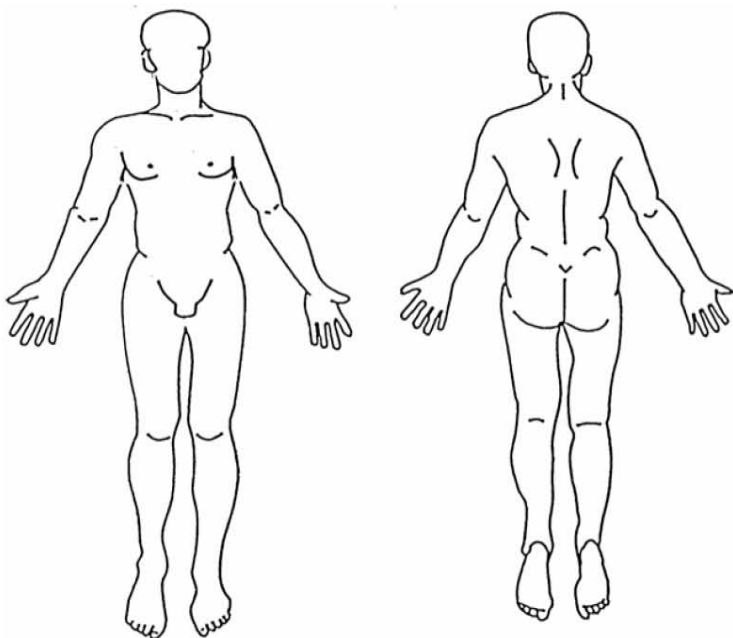
Patient/Representative Signature: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_

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 = 0000000      Stabbing = ////////////////  
 Burning = XXXXXXX                      Deep Ache = ZZZZZZZZ



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: \_\_\_\_\_