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Kinder, LA 70648

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Physical Therapy
Mitch Talley, PT, DPT
Kevin Touchet, PT, MPT
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Occupational Therapy
Jessie Broussard, LOTR
Scott Meche, LOTR, MBA

Thank you for choosing Kinder Therapy Group to provide your therapy needs. You will be happy to know that we pride ourselves on our quality of care and utmost compassion, every step of the way.

Our goal is to provide you with excellent care, in a family-oriented and supportive environment. It is important to us that we meet your expectations as you progress towards your therapy goals.

You will find our staff ready to answer your questions and address your needs - from insurance and billing to meeting your scheduling requirements. If we can assist you with anything, please do not hesitate to let us know.

It was a pleasure to have met you and welcome to our family!

Thank you,
Kinder Therapy Group Staff

Kinder Therapy Group
Patient Information

Date:________________________

First Name:_______________________________________ **MI:**___________ **Last Name:**___________________________________

Social Security Number: __________________________________ **Gender:** Male Female **Date of Birth:** ______________________

Marital Status: Single Married Widow Divorced **Status:** Student Employed Retired

Mailing Address:____ **Physical Address:**____

City:____ **State:**_____________________ **Zip:**_________________

Home Phone #:____ **Cell Phone #:**____

Was condition related to: ( ) **Employment** ( ) **Auto Accident** ( ) **Other**___________________________________

Date condition / Accident began:____________________________

Referring Physician:____ **Next Appointment:**______________________________

Family Physician:____

Employer:____ **Employer Phone #:**____________________________________

PRIMARY INSURED'S INFORMATION

(This is the person, if different from the patient, whose name appears on your insurance card. If more than one name appears on the insurance card, the primary or first person named on the card.)

Name:____ **Address:**____

City:____ **State:**______________ **Zip:**_______________________________________

Relationship to Patient:______________________ **SS #:**___________________________ **Date of Birth:**_______________________
(month/day/year)

Please provide contact information where someone can be reached in case of EMERGENCY while patient is receiving therapy

Name:_____________________________________ **Relationship:**________________ **Phone Number:** _________________________

Is this an emergency contact? Y N

Is this person permitted to discuss your medical information? Y N

ARE YOU CURRENTLY RECEIVING HOME HEATLH SERVICES? ( ) YES ( ) NO

(Home Health Service includes any medical care or assistance by a nurse or doctor or therapist in your home.)

Have you received physical therapy for this condition before? ( ) Yes ( ) No

Please tell us how you heard about Iowa Therapy Group ?

Radio Ad___ **Newspaper Ad** ___ **Physician** ___ **Friend** ___ **Other** _______________________________________

Medical History   Name: ______________________________   Date: ______________________

Existing or Relevant Previous Conditions

Condition		Condition		Condition	
Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No

Two or more falls in the last year? ◯ Yes ◯ No

Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Current Medications

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

- ☐ **Currently not taking any medications**
- ☐ **Are you pregnant**
- ☐ **Do you have a pacemaker**

Kinder Therapy Group
Initial Evaluation Worksheet

Date:______________________________________

Patient Name:___________________________________

Address:_______________________________________

Physician:_____________________________________

Diagnosis:_____________________________________

____

Short Term Goals **Plan**

Long Term Goals **Frequency/Duration**

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History

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Chief Complaint

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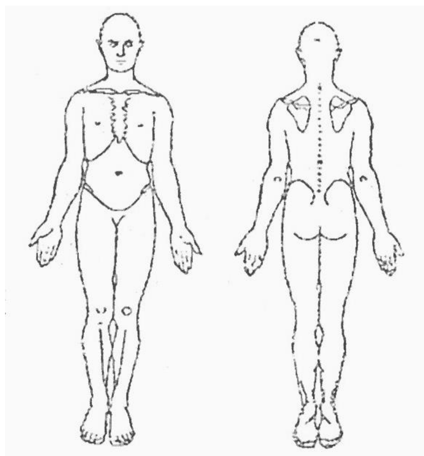
Symptoms this episode to be marked on body diagram



General Observation

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Posture

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Range of Motion

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Strength

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Sensation

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____

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Palpation

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Repeated Movement Testing

Pretest:_______________________________________

RFIS:____

REIS:____

RFIL:____

REIL:____

Other:____

Assessment

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____

Intramuscular Manual Therapy aka Trigger Point Dry Needling (TDN) Consent Form

IMT / TDN involves placing a small needle into the muscle at the trigger point which is typically in a n area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.

IMT / TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like any treatment there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

Risks of the procedure:

Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your IMT / TDN provider. If a pneumo is suspected you should seek medical attention from your physician or if necessary go to the emergency room.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT / TDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily Fluids?

Yes NO If you marked yes, please discuss with your practitioner.

____

Please print your name.

____ ______________________________

Signature Date

☐ **I was offered a copy of this consent and refused.**

Tri-Parish Therapy Group

Kinder Therapy Group

Clinic Policies

Thank you for choosing KINDER THERAPY GROUP to provide your therapy needs. You will be happy to know that we pride ourselves on our quality of care and utmost compassion—every step of the way. Please read over the following policies, ask any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. Please make sure you provide our office with an updated copy of your insurance and let us know of any changes in insurance policies. Not letting us know of any changes could result in denial from your insurance and any charges occurred will be your responsibility. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles**. ALL copayments and unsatisfied deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a breach of contract.
3. **Attorney billing.** If you have been in any accident and we are billing through an Attorney, please be prepared to provide all info needed. We require a Letter of Guarantee along with a retainer fee from your Attorney before we can schedule your initial visit. If your case is dismissed at any time with unpaid balance, then it will become your responsibility.
4. **Worker's Compensation**. It is your responsibility to provide our office with all information regarding your claim. We will submit 1010 with all information given to get approval for your therapy. Once approval is received, we will then set up your initial visit. If at any time your claim is denied with unpaid balance, then it becomes your responsibility.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonable can to help get your claims paid. We submit claims daily and providing us with the right information will aid in having your claim processed quickly. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claims is your responsibility whether your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company, we are not party to that contract.
6. **Nonpayment.** If your account if over 120 days or more where no effort has been made to contact our billing office for payment arrangements, it could be turned over to an outside collection agency. You will be responsible for any collection fees. We offer payment arrangements to take care of any balance you have incurred.
7. **Returned checks**. The charge for returned check is @25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount. You may be placed on a Cash or Card Only basis following an NSF Check.
8. **Missed appointments**. If you miss three appointments without giving us sufficient cancellation notice of least 24 hours, you may be discharged. If you are Medicare primary you may not go longer than 2 weeks without being seen by one of our therapists or we will have to discharge.
9. **Late arrival policy**. We expect all patient to show up at their scheduled appointment time. If you are more than 15 minutes late you may be rescheduled. Arrival on time assures our schedule flows more smoothly and each patient is taken care of in a timely manner. There are no standing appointments.
10. **Patient dismissal**. Termination of the Therapist-patient relationship can occur at the request of the patient or therapist when the relationship is no longer proceeding in a mutually productive manner. Circumstances that may result in dismissal from our office include: (a) Noncompliance with treatment (b) Threatening, demanding or abusive behavior directed toward our staff or therapists (c) Failure to keep appointments (d) Failure to pay consistent with policy listed above
11. **Release of information**. I authorize KINDER THERAPY GROUP providing services on behalf of patient to release all billing and medical information to physicians or institutions providing follow up care. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to the office manager.
12. **Assignment of Benefits**. I authorize any third-party payer to pay directly to KINDER THERAPY GROUP all benefits due and payable as a result of services rendered.
13. **Acknowledgment of responsibility to pay for services**. I understand, acknowledge, and agree that, except as provided by law, and in consideration of the services provided. I will pay any charges which for any reason are not paid by any third-party payer.
14. **Medicare patients**. I request that payment of authorized Medicare benefits to be made to KINDER THERAPY GROUP all benefits due and payable as a result of services rendered. I authorize any holder of medical information about me to

release to the Center for Medicare and Medicaid Services and its agents any information needed to determine those benefits or the benefits payable for related services.

15. **Authorization and Release**. Insurers and managed care companies occasionally review medical charts to ensure compliance with company procedures. I understand that my chart may be selected for such a review and that the confidentiality of the information in my chart will be preserved and I hereby consent to such review and release the Therapist and any such insurer or managed care company for liability for any reasonable review of my chart.
16. **Acknowledgement of receipt of Privacy Notice.** I have been presented with KINDER THERAPY GROUP Privacy Policy detailing how my private health information may be used and disclosed as permitted under federal and state law. (Copy given upon request) I understand the contents of the Notice. I understand that I may request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that KINDER THERAPY GROUP is not required to agree to the restrictions requested.
17. **Permission to Leave/Send Appointment Messages**. My signature below indicates my permission for KINDER THERAPY GROUP to leave recorded messages regarding the date, time, and location of my scheduled appointment. My signature below also gives permission for text messages and emails to be sent to me regarding appointment times.
18. **Consent to photography**. "Clinical photography" is the recording or reproduction of images by still photography, videotaping, or other means, whether in digital or other formats, within the healthcare setting for purposes of assisting with identification, treatment, payment for services, and/or health care operations, including the training and education of the workforce withing our office. I hereby consent to being photographed, videoed, or recorded while receiving treatment at this office. I authorize the use and disclosure of such clinical photography for the purposes set forth above. I and my successors or assigns hereby hold KINDER THERAPY GROUP and its employees and any of person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from activities authorized herein.
19. **Confidential Communication Request. Individual Authorized to Discuss My Medical Information**: The individuals listed below have my permission to obtain and/or discuss my personal condition for all encounters until I change the information below:

Name______________________________Relationship__________________________Phone Number_________________

Name______________________________Relationship__________________________Phone Number_________________

Name______________________________Relationship__________________________Phone Number_________________

I request that any and all communication with me be handled in the following manner:

Leave a Message to call the office: ○ On answering machine ○ With whoever answers phone ○ On cell phone

Leave information about appointments: ○ On answering machine ○ With whoever answers phone ○ On cell phone

I have read and understand all the above policies and agree to abide by its guidelines:

____ ________________________________ ______________

Patients Name Legal Guardian's Name (if minor) Date

Name ___________________ Birthdate________ Doctor ________________ Today's Date ________

A Survey from Your Healthcare Provider

Part of routine screening for your health includes reviewing mood and emotional concerns.

During the past two weeks, have you often been bothered by of the following problems?

Feeling down, depressed, irritable or hopeless? ❐ Yes ❐ No

Little interest or pleasure in doing things? ❐ Yes ❐ No

If you answered "Yes" to either question above, please answer all questions below.

During the past two weeks, how often have you been bothered by of the following problems?	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

❐ Not difficult at all ❐ Somewhat difficult ❐ Very difficult ❐ Extremely difficult

For Office Use Only: Total Score

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PHOTOGRAPHY CONSENT/RELEASE

I, ___________________________, being of full age and majority, do hereby consent to allow Kinder Therapy Group to utilize my verbal testimonial, likeness, photograph, video, name, or image in conjunction with marketing and/or advertising materials, regardless of the chosen medium, including but not limited to photographs or video taken for marketing materials. In so doing, I hereby waive any claims, rights, or causes of action I may otherwise assert or hold to or against Kinder Therapy Group. I agree and affirm that I render this consent with complete knowledge and of my own accord and desires. This consent shall be effective this _____ day of ________, 20___.

Signature: _____________________________

Print Name: _______________________

Date: ____________________________