R. JASON KENT
PHYSICAL THERAPY

First Name: _____ **MI:**____ **Last Name:** _____ **Sex: M / F**

Date of Birth: _____/_____/_____ **Social Sec #:** _____-_____-_____ **Marital Status: S M D W**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:**_____

Email Address: _____

(By providing your email address, you expressly consent to receive emails from us. We do not provide or sell your email address to 3rd parties)

How did you hear about us?: _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Patient Employer: _____ **Occupation:** _____

Emergency Contact: _____ **Phone:** _____

Relationship to Patient: _____ **Records Release: Yes _____ No _____**

Primary Medical Insurance: _____ **ID #:** _____

Policy Holder Name: _____ **Relationship:** _____

Policy Holder's Date of Birth: _____/_____/_____ **Policy Holder's SSN:** _____

Secondary Medical Insurance: _____ **ID #:** _____

Policy Holder Name: _____ **Relationship:** _____

Policy Holder's Date of Birth: _____/_____/_____ **Policy Holder's SSN:** _____

***Have you received Physical Therapy anywhere else in 2026? Yes _____ No _____ Dates?_____**
***Have you received Physical Therapy at home in 2026? Yes _____ No _____ Dates?_____**
***Is this treatment due to injuries sustained in an accident: Yes _____ No _____**

***Is your visit related to a work injury case? Yes _____ No _____ Claim #:_____**

Work Comp Adjuster: _____ **Phone #:** _____

***Is your visit related to a Motor Vehicle Accident? Yes ____ No ____ Claim #:** _____

Adjuster:_____ **Phone #:** _____

***Are you represented by an attorney? Yes ____ No____**

If yes, Attorney Name: _____ **Phone #:** _____

****IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE LET THE FRONT DESK KNOW***

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IMPORTANT COMPANY POLICIES FOR A SUCCESSFUL RELATIONSHIP

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of R. Jason Kent Physical Therapy, LLC. This form must be completed in its entirety and must be provided to R. Jason Kent Physical Therapy, LLC prior to initiation of therapy services.

AUTHORIZATION OF PAYMENT: I hereby authorize my insurance company to make payment directly to R. Jason Kent Physical Therapy, LLC for any treatments I may receive. In the event my insurance company/attorney/auto insurance/work comp forwards payment directly to me instead of to R. Jason Kent Physical Therapy, LLC, I will immediately deliver such payment to them. I also fully understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and court costs, in addition to the outstanding balance. I authorize the release of any information necessary to process my insurance claims or facilitate payment of my account by a third party. I acknowledge that I have been given the opportunity to read over the Financial Policy posted in our front lobby. *If my account is turned over to a collection agency, there will be a 30% collection fee added to your balance.*

NOTICE OF PRIVACY: I acknowledge that I have been given the opportunity to read over the Notice of Privacy Practices posted in our front lobby.

CONSENT TO TREATMENT: I consent to rehabilitation and related services at R. Jason Kent Physical Therapy, LLC. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I also consent to Telehealth/video services, e-visits, telephone assessments and Virtual Check In sessions if I choose to participate in any of these 4 virtual services which are all new services added to physical therapy during COVID-19.

WAIVER AND RELEASE: I hereby release, discharge and acquit R. Jason Kent Physical Therapy, LLC, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

LIABILITY: I know and agree that R. Jason Kent Physical Therapy, LLC is not responsible for loss or damage to personal valuables.

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

USE OF CELL PHONES: We realize emergencies may arise and therefore we allow you to carry your cell phone during your session, however, please be courteous and set your phone to silent mode or turn it off. Please refrain from carrying on phone conversations in the treatment areas out of respect for other patients.

Patient/Guardian Signature _____ **Date** _____

Print Patient Name: _____

Witness Signature _____ **Date** _____

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Medical History Form

Name: _____ **Date:** _____

Dominant Side: [ ] Right [ ] Left **Involved Side:** [ ] Right [ ] Left **Height:** ____ ft ____ in **Weight:** _____ lbs

How did your injury occur? [ ] Work Incident [ ] Fall [ ] Trauma [ ] Motor Vehicle Accident [ ] Impact
[ ] injury [ ] Degenerative Process [ ] Recreation/Sport [ ] Unknown

DATE OF INJURY / CONDITION / ACCIDENT: _____

Briefly describe your symptoms: _____

_____

As the day progresses, do symptoms: [ ] Increase [ ] Decrease [ ] Stay the same

Do your symptoms **wake you up at night?** [ ] Yes [ ] No

What alleviates your symptoms? _____

_____

Medications you are currently taking? [ ] Yes [ ] No **(Please fill out the attached Medication List for our records.)**

Please list any recent/relevant surgeries or hospitalizations:

_____ **Date:** _____**DR.:**_____

_____ **Date:** _____**DR.:**_____

Do you have a pace-maker? [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No **Packs per day:** _____ **Cigars/pipes per day:** _____

Have you smoked in the past? [ ] Yes [ ] No **Year quit:** _____

How many days per week do you consume alcoholic beverages? _____ **How many drinks per day?** _____

How often do you exercise? [ ] 5+ days a week [ ] 1-2 days per week [ ] Occasionally [ ] Never

What do your athletic/recreational activities entail? _____

_____

Other Providers you have seen for this problem: [ ] Family Practitioner [ ] Massage Therapist [ ] Podiatrist
[ ] Internist [ ] Neurologist [ ] Rheumatologist [ ] Chiropractor [ ] Orthopedist [ ] Pain Management
[ ] Primary Care Physician **Other:** _____

***Have you had a fever in the last 3 weeks prior to today's appointment?** [ ] Yes [ ] No
Please explain the cause of fever if known: _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

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Medication List

Patient Name: _____ Date: _____

Please list ALL Medications that you are currently taking. This list should include any and all prescription medication, herbal supplements, and vitamins.

Medication	Dose	Frequency	Route	Purpose	Physician

Pharmacy: _____ Phone #: _____

Patient Signature: _____

R. JASON KENT
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PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, R. JASON KENT PHYSICAL THERAPY, LLC now has the ability to provide our patients with information via e-mail and/or text messaging. If you wish to have the opportunity to receive information including appointment reminders, please complete the form below.

R. JASON KENT PHYSICAL THERAPY, LLC believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or person information will be sent from R. JASON KENT PHYSICAL THERAPY, LLC via e-mail or text messaging. R. JASON KENT PHYSICAL THERAPY, LLC does not share the names, e-mail addresses, nor telephone numbers of patients with any other company or other patient.

Please print all information neatly and legibly.

Name:_____

E-mail address:_____

Cell Phone:_____

Please initial below:

_____ Yes, please sign me up to receive e-mail, phone call and text messaging confirmations

Preferred Contact Method for Appointment Notification: Circle one: EMAIL TEXT PHONECALL

_____ I DO NOT wish to be contacted via e-mail. (Text messaging only)

_____ I DO NOT wish to be contacted via text messaging. (E-mail only)

_____ I DO NOT wish to be contacted by either text messaging or e-mail.

I hereby give R. JASON KENT PHYSICAL THERAPY, LLC permission to send messages to me via e-mail and/or text messaging as means of communication as indicated by my selection above.

Name:_____ Date:_____

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NO SHOW/CANCELLATION POLICY ACKNOWLEDGEMENT

At **R. Jason Kent Physical Therapy, LLC**, our goal is to help all patients reach a fully recovered state. During your evaluation, your physical therapist will provide you with a plan of care and will inform you of the required number of visits you will need to help you achieve your goals. In order for you to receive the best recovery, it is extremely important that all of your appointments be attended. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy carefully and sign at the bottom.

1. We know that **you will not reach full recovery if you do not attend your appointments.** After your evaluation, we will work with you to schedule out all of your appointments. In order for you to have the best chance at recovery, you will need to attend **each visit.**
2. **Please note:** It is our goal to begin your treatment session on schedule therefore; we need you to **arrive at least 5 minutes prior to your follow –up appointments dressed and ready to begin on time**. This will allow our front office to handle their responsibilities without cutting into your treatment time.
3. If you are late for your appointment, you are missing time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Therefore, if you are going to be late for your appointment, you need to **call us immediately** so we can prepare for your late arrival and consult with your therapist. If you are more than **15 minutes late**, your session may need to be rescheduled and if that occurs, you will be charged a missed visit fee.
4. If you need to cancel or change an appointment for any reason, we require a 24 hours notice from the time of your appointment. This notice should be done during **business hours so that we have enough time to help someone else who needs an appointment time.**
5. There is a **$30 fee if you do not provide us with at least a day's notice of your appointment change or cancellation. This is non-negotiable and it's your responsibility as insurance will not cover it.** If you're a worker's comp patient, we are required to notify your claims adjuster if you cancel or no-show an appointment. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment. **Patients who have multiple same-day cancellations or no-shows, will be removed from the schedule. We will also notify your physician of your non-compliance.**

We look forward to working with you to meet your physical therapy goals!

I have read this policy and by signing below, I am indicating that I understand it and the expectations of me.

Patient/Guardian Signature _____ **Date** _____

Print Patient Name: _____

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Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Signature_____ **Please Print**_____

Date _____