Kinetic Physical Therapy PA

Angelo A Stefanides PT, OCS
1080 6th Ave North
Naples, FL 34102-5602

NAME:_____ DATE OF BIRTH:_____ AGE:_____

LOCAL ADDRESS:_____ SEX:_____MALE_____FEMALE

CITY:_____ STATE:_____ZIP:_____ HOME PHONE:_____

WORK PHONE:_____ CELL PHONE:_____

EMAIL:_____

CHECK APPROPRIATE:_____MINOR_____SINGLE_____MARRIED_____WIDOW (ER)_____OTHER

PLACE OF EMPLOYMENT: _____ CITY:_____ STATE:_____ ZIP_____

IN CASE OF EMERGENCY, NOTIFY:_____ PHONE:_____

RELATIONSHIP TO PATIENT:_____

OUT OF STATE ADDRESS: _____ CITY:_____ State:_____Zip:_____

INSURANCE USED FOR THIS CLAIM:
_____AUTO_____MEDICARE_____WORK COMP_____ PRIVATE_____NONE

NAME OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

INSURED'S BIRTHDAY: _____ADDRESS OF INSURED, IF DIFFERENT FROM PATIENT: _____

CITY: _____ STATE:_____ ZIP:_____ PHONE:_____

How did you hear about office?_____

FAMILY/REFERRING PHYSICIAN:_____ ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ PHONE:_____

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

PLEASE FILL OUT AS ACCURATELY AS POSSIBLE

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NAME:_____

Date problem began, got worse or Date of Current Surgery:_____

BRIEF DESCRPITION OF PROBLEM:_____

HAVE YOU ALREADY HAD TREATMENT FOR THIS PROBLEM?_____YES_____NO

IF YES, PLEASE BRIEFLY DESCRIBE THE TREATMENT:

_____

_____

I HAVE OR HAVE HAD: CIRCLE YES OR NO

DIABETES	YES	NO	OSTEOPROSIS	YES	NO
PACEMAKER	YES	NO	INJURIES:NECK, HEAD, BACK	YES	NO
HIGH/LOW BLOOD PRESSURE	YES	NO	FRACTURES, SPRAINS	YES	NO
SEIZURE/CONVULSIONS	YES	NO	ALLERGIES	YES	NO
RHEUMATIOD ARTHRITIS	YES	NO	CANCER	YES	NO
METAL IMPLANTS	YES	NO	EMPHYSEMA/ASTHMA	YES	NO
STROKE/PARALYSIS	YES	NO	MIGRAIN HEADACHES	YES	NO
HISTORY OF FALLS	YES	NO	HEIGHT & WEIGHT	_____'_____"	_____LBS

PREVIOUS SURGERIES (Use other side if needed):

_____

_____

LIST ALL MEDICATIONS YOU ARE TAKING (Use other side if needed):_____

_____

I HEREBY CONSENT TO PHYSICAL THERPAY TREATMENT PROVIDED TO ME BY Kinetic Physical Therapy PA. AND/OR AS PRESCIBED BY MY PHYSICAN.

I REQUEST THAT PAYMENT OF INSURANCE BENEFITS BE MADE ON MY BEHALF TO Kinetic Physical Therapy PA. FOR ANY SERVICES RENDERED TO ME BY THAT CLINIC. I UNDERSTAND THAT PHYSICAL THERAPY SERVICES CAN VARY DEPENDING ON MY NEEDS AND THE PLAN OF CARE MY PHYSICAL THERAPIST DEVELOPS FOR ME. I AUTHORIZE Kinetic Physical Therapy PA. TO RELEASE TO MY INSURANCE COMPANY AND ITS AGENT ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

THIS OFFICE IS OWNED SOLEY BY Angelo A Stefanides, PT. AND NO OTHER HEALTHCARE ENTITIY OR PROVIDER. THERE IS NO COMPENSATION DERIVED BY YOUR PHYSICIAN IN SENDING YOU TO THIS OFFICE. YOU THE PATIENT, HAVE THE RIGHT TO OBTAIN PHYSICAL THERAPY SERVICES AT THIS OR ANY FACILITY OF YOUR CHOICE.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

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ACKNOWLEDGEMENT FORM
FOR
NOTICE OF PATIENT INFORMATION PRACTICES

I have read and fully understand Kinetic Physical Therapy's Notice of Information Practices. I understand that Kinetic Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations, if I notify the practice. I also understand that Kinetic Physical Therapy will consider requests for restriction on a case by case basis but does not have to agree to the requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Kinetic Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____ _____
Signature Date

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Appointment Cancellation Policy CHANGE EFFECTIVE JANUARY 1, 2024

We realize that coming to physical therapy several times a week can be exhausting. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 24 hours' notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment**. If you miss an appointment without contacting our office, this is considered a missed appointment. A fee of $100.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.** No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 25 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $100.00 cancellation fee will be charged.

Our office does have an answering system that can take your calls 24 hours per day.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

Thank you for your understanding.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____, have received a copy of Kinetic Physical Therapy Appointment Cancellation Policy.

_____ _____

SIGNATURE DATE

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TO OUR MEDICARE PATIENTS: **January 2026**

Please be advised that we are a Medicare Part B participating provider. What this means is that we accept Medicare's fee schedule as payment for our services. About 15 days after we submit you claim, Medicare will reimburse us directly for 80% of their fee schedule. You are responsible for checking your second insurance coverage of the remaining 20% plus your 2026 deductible of **$288**. ***Under no circumstances do we waive you deductible or copayment, to do so, is considered fraud by the federal government.***

Remember, for Medicare to pay for you treatments, you have to meet the following criteria:

1. Your present treatment ***plan must have nothing to do with an automobile accident, legal case, or be covered by your employer medical policy.***
2. **YOU MUST HAVE** a physician's referral or written prescription by your doctor for physical therapy. It is your responsibility to physically be re-examined by you physician after 90 days. If you do not, Medicare will deny payment for those visits after the 91st day and we will then collect the entire visit fee from you. Script needs to be initiated within 30 days from script date.
3. If you initiated physical therapy with an out for state prescription, you must present this office with a Florida MD prescription within 28 days of your first visit, in order to be in compliance with the laws of the State of Florida.
4. **You must be discharged from any home health care services** prior to initiating outpatient physical therapy. Medicare will not pay for **both** home healthcare and outpatient care at the same time.
5. There is a **$2,480.00** cap for outpatient physical therapy/speech therapy combined, per calendar year in all settings except the hospital rehabilitation department. This translates to approximately 12 to 18 visits at Kinetic Physical Therapy.

I acknowledge that I have read the above policy, and I understand that I am responsible for my 20% co-payment, any deductible not met, and for notifying Kinetic Physical Therapy if I have not met the above-mentioned criteria.

Have you received physical therapy or speech therapy during this calendar year? **2026** Yes_____ No _____

If yes, Where? _____ Last Date of Service:_____

Have you had any health care services (including physical therapy) provided in your HOME in this calendar year? **2026 I**.E. therapy, wound care, diabetic care, etc. Yes_____ No_____

If yes, last date of service: _____ Name of Agency:_____

_____ _____

Signature of Patient Date

We truly appreciate the opportunity to assist you with your recovery. Let us know if there is anything more we can do for you.