KINETIC
HOME THERAPY SERVICES LLC.

Patient Intake Form

Thank you for choosing Kinetic Home Therapy Services. We're honored to support your journey toward better health and mobility. Please fill out the following form to help us better understand your needs, preferences, and goals so that we can match you with the most appropriate therapist and provide you with the highest level of personalized care.

Personal Information

Full Name: _____

Preferred Name (if different): _____ Date of Birth (mm/dd/yyyy): _____

Gender: _____

Address: _____ City: _____ Zip Code: _____

Secondary Address (if applicable): _____

Phone Number: (_____) _____ - _____ Email Address: _____

Insurance Information

Primary Insurance Provider: _____

Policy / ID Number: _____

Secondary Insurance Provider: _____

Policy / ID Number: _____

Plan Type: □ PPO □ HMO □ POS □ DMO □ Medicare □ Other: _____

If you have trouble reading your insurance information, please take a photo and email it to info@kinetichometherapy.com.

Please Note: Kinetic Home Therapy Services is an out-of-network provider for all insurance carriers except Medicare. If you have out-of-network benefits, your plan may cover a portion of the services. Our billing team will verify your eligibility and communicate your coverage and any out-of-pocket responsibility prior to starting services.

Primary Physician Information

Physician's Name: _____ Phone Number: _____

Office Address: _____

Have you seen your primary physician in the last 6 months?
☐ Yes ☐ No

Date of most recent visit (if known): _____

Referral Information

How did you hear about us?
☐ Referred by Doctor or Medical Group (Name): _____
☐ Referred by Home Care Agency (Name): _____
☐ Senior Center / Health Fair (Event Name): _____
☐ Family or Friend
☐ Online / Social Media
☐ Other: _____

Tell Us About Your Situation

Briefly describe why you are seeking therapy (what happened or what you're struggling with):

_____

_____

_____

Have you received therapy before? ☐ Yes ☐ No

If yes, when and for what condition(s)? _____

Which services are you interested in?
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ Balance & Fall Prevention
☐ Post-Surgical Rehab
☐ Mobility or Strength Training
☐ Neurological Rehab (e.g., Stroke, Parkinson's)
☐ Home Safety Assessment
☐ Other: _____

What are your top 2–3 goals for therapy?

How would you rate your current level of independence at home?
□ Fully Independent □ Needs Some Assistance □ Dependent

What is your current level of pain?
(1 = Not Bad, 5, Mild Discomfort, 10 = Extreme) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Do you use any assistive devices?
□ Cane □ Walker □ Wheelchair □ Other: _____

Do you live alone? □ Yes □ No

If no, who do you live with? _____

Are you currently receiving any other in-home services (nursing, aides, etc.)? □ Yes □ No

If yes, please list: _____

Emergency Contact

Name: _____

Phone Number: (_____) _____ - _____ Email Address: _____

Relationship to Patient: _____

Copay and Financial Responsibility

Please check all that apply:

□ I understand a **copay or coinsurance** may be required for each session.

□ I understand I am responsible for any **deductible** not yet met.

□ I understand that as an **out-of-network provider**, coverage may vary based on my plan.

□ I would like help understanding my **out-of-network benefits**.

□ I will be paying **privately (out-of-pocket)** for services.

□ My insurance provider has **pre-authorized** therapy sessions.

□ I am using **Medicare** as my primary insurance.

Please Note:

While we strive to honor individual preferences whenever possible, due to a high volume of patients and therapist availability by region, we may not be able to accommodate requests for a specific language, gender, or therapist—especially depending on the county in which you reside. Kinetic Home Therapy Services currently provides care in Morris, Essex, Passaic, and Bergen counties, and we will do our best to match you with a therapist who aligns with your needs.

Please also be aware that the evaluating therapist may not be the same as your ongoing treating therapist, based on scheduling and availability. However, if at any point you are unsatisfied or feel you would benefit from a different provider, we are happy to assign a new therapist to ensure your comfort and progress.

Consent and Signature

By signing below, I confirm that the information provided in this form is accurate and complete to the best of my knowledge. I understand that this intake form is the first step in initiating services with Kinetic Home Therapy Services and does not yet constitute a full enrollment in a therapy plan.

I consent to be contacted by a licensed physical, occupational or speech therapist who will follow up to schedule an initial evaluation based on the information provided. I acknowledge that additional paperwork, including consent for treatment, privacy disclosures, and insurance authorizations, will be required prior to the start of therapy services.

I also understand that submission of this form does not guarantee acceptance or coverage by my insurance provider, and that all financial responsibilities will be reviewed and clarified with me in advance.

Signature: _____ Date: _____

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