PRO ACTIVE
PHYSICAL THERAPY & SPORTS MEDICINE

Pro Active Physical Therapy & Sports Medicine

Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times give one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $30 or $60 depending on appointment type.

   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Pro Active Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Pro Active Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

   Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Pro Active Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. **CONSENT FOR EMERGENCY CONTACT INFORMATION**

   Person to contact in case of an emergency:

   ____________________________ ____________________ ___________________
   Name Telephone Number Relationship:

   By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

   ____ ______________
   Signature of Patient or Legally Responsible Person Date

   ____ _______________
   Printed Name of above Date

PRO ACTIVE PHYSICAL THERAPY & SPORTS MEDICINE

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke?** ☐ **Yes** ☐ **No**
Sex: ☐ **Male** ☐ **Female If female,** are you currently pregnant? ☐ **No** ☐ **Yes If yes, what trimester:** ☐ 1st ☐ 2nd ☐ 3rd				

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No ☐ Yes	Cancer	☐ No ☐ Yes	Arthritis	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Heart Condition	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Respiratory Problems	☐ No ☐ Yes
Other: ______				Pacemaker	☐ No ☐ Yes

Who referred you to physical therapy? ______

Primary Physician ______

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates):

______

Recent flare-up? ☐ No ☐ Yes If yes, when

______

What activities are limited by this condition? (e.g. lift, reach):

______

How did your injury/symptoms occur?

______

What do you expect to accomplish with physical therapy?

______

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better?
☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? ______

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind? ______

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

☐ Physical therapy? If yes, when? ___/___/___to ___/___/__

What was done? ______

☐ Chiropractor? If yes, when? ___/___/___to ___/___/___

What was done? ______

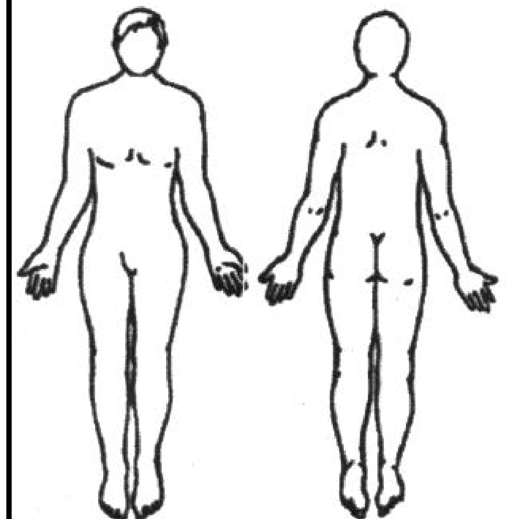
☐ Medications: ______

☐ X-ray ______ ☐ MRI ______

☐ CT scan ______ ☐ Other: ______

Indicate on body diagrams **where** your symptoms are located

■ = Pain *III* = Numbness



Comments:______

______

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PRO ACTIVE PHYSICAL THERAPY & SPORTS MEDICINE
CURRENT MEDICATIONS LIST REPORT

PATIENT NAME: **DATE:**

LIST ALL THE PRESCRIPTION MEDICATIONS YOUR ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

LIST ALL OVER-THE -COUNTER MEDICATIONS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Pro Active Physical Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among Pro Active Physical Therapy personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for Pro Active Physical Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that Pro Active Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand Pro Active Physical Therapy for **<u>Worker's Compensation Cases</u>**, will release the minimum necessary PHI/ePHI to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Pro Active Physical Therapy is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_______] Spouse/Children:____

[_______] Other: ____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number: ____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Pro Active Physical Therapy and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

______________________________________ ________________ _______________________

Signature of patient or legal representative Date Relationship to Patient

____

Printed name of patient

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Trigger Point Dry Needling (TDN) Consent Form

Trigger point Dry Needling involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms.

TDN is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Risk 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. Thy symptoms of 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 rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. 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 does not have a cutting edge, the likelihood of any significant tissue trauma from 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

This is not a requirement, it is an option that you and your therapist can discuss during your visit.