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 given 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 can result in a cancel/no show charge.

   **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. **FINANCIAL POLICY:** A medical insurance policy is a contract between you and your insurance company. Coverage depends upon your insurance company and the specific plan you have chosen. Pro Active Physical Therapy is contracted with most insurance companies and as a service to patients, we agree to submit your claims directly to them. You may need a current physician’s prescription/referral for therapy services in order to submit your claim. In order for us to submit a claim to your insurance company, we will need a copy of your insurance card. Any questions you have regarding insurance coverage or benefits should be directed to your insurance plan.

   All patient cost shares (co-payments, co-insurances and deductibles) are due at the time of treatment. For patients with co-insurance and/or deductibles, we will be asking for a good-faith payment. A good-faith payment is an estimate of what you will owe. Once the insurance carrier adjudicates the claim, we may have to bill you for any remaining balance.

   **Medicare Patients:** If you choose to schedule therapy without a physician’s prescription/referral, we MUST obtain a signed therapy plan of care from your physician within 30 days of your initial visit. Also, you must be discharged from any home health care services or agency prior to initiating outpatient therapy. Medicare will not pay for both home health and outpatient care simultaneously.

   **Motor Vehicle:** We will bill your Auto Insurance as a courtesy to you. If you do not have a direct PIP Claim, you can choose to submit your personal health insurance or pay at the time of service.

   **Work Injury Claims:** Medical expenses resulting from a workplace injury/disease will be submitted to the workers’ compensation program on an open claim. However, if a claim is denied for any reason, the patient will be fully responsible for the total cost of the care provided.
Cash-Pay Policy: We offer a prompt pay rate for services paid in full at the time of service. This discount is based on the administrative savings to our practice when receiving payments up front, rather than billing for services. We will not bill your insurance company for services provided under this arrangement. No forms will be produced now or in the future for you to submit claims for insurance billing.________(initial)

Rebilling Policy: It is the patient’s responsibility to provide us with correct billing information. If incorrect billing information is provided and later the correct information is provided, but it is after the timely filing deadlines of your Payor, than you will be responsible for full bill.________(initial)

Unaccompanied Minors Policy: Pro Active Physical Therapy is authorized to provide treatment to a minor as appropriate when they arrive to an appointment unaccompanied by a parent/guardian; this may include changes in the current therapy the minor is receiving including treatments and exercises. The above financial policy is applicable to guarantor of unaccompanied minor.________(initial)

4. INSURANCE BENEFITS: Pro Active Physical Therapy as a courtesy, will attempt to verify the patient’s benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that at times, insurance carriers will not provide accurate benefit information, hence it is the patients responsibility to understand their own insurance benefits. The responsible party understands that the verification of benefits and authorization is done as a courtesy and not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.________(initial)

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

5. ASSIGNMENT OF BENEFITS: I hereby assign to Pro Active Physical Therapy all my rights and claims for reimbursement under my health insurance policy and such other insurance policies as I may identify in my Insurance Verification Form given to Pro Active Physical Therapy. I agree to provide information as needed to establish my eligibility for such benefits.

6. 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
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 Worker’s Compensation Cases 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
MEDICAL HISTORY/SUBJECTIVE INFORMATION

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

<table>
<thead>
<tr>
<th>Your Name:</th>
<th>Today’s Date:</th>
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<tr>
<th>Date of Birth:</th>
<th>Age:</th>
<th>Height:</th>
<th>Weight:</th>
<th>Do You Smoke? □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex: □ Male □ Female</td>
<td>If female, are you currently pregnant? □ No □ Yes</td>
<td>If yes, what trimester: □ 1st □ 2nd □ 3rd</td>
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Have you ever been diagnosed with any of the following?

- Tuberculosis □ No □ Yes
- Diabetes □ No □ Yes
- Heart Condition □ No □ Yes
- Other: ____________________________________
- Cancer □ No □ Yes
- Hepatitis □ No □ Yes
- Epilepsy □ No □ Yes
- Arthritis □ No □ Yes
- Stroke □ No □ Yes
- Respiratory Problems □ No □ Yes
- 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: ________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
# Current Medications List Report

**PATIENT NAME:**

**DATE:**

**List All the Prescription Medications You Are Currently Taking**

<table>
<thead>
<tr>
<th>Name of the Medication</th>
<th>Dosage (how many or how much you take)</th>
<th>Frequency (how often do you take it)</th>
<th>Route (how do you take it, i.e., by mouth, injection etc.)</th>
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**List All Over-the-Counter Medications**

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<th>Name of the Medication</th>
<th>Dosage (how many or how much you take)</th>
<th>Frequency (how often do you take it)</th>
<th>Route (how do you take it, i.e., by mouth, injection etc.)</th>
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**List All Herbs, Vitamins, Minerals, Nutritional Supplements**

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<th>Name of the Medication</th>
<th>Dosage (how many or how much you take)</th>
<th>Frequency (how often do you take it)</th>
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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.