DYNAMIC PHYSICAL THERAPY

Patient Information Form

Last Name_____ First Name_____ MI _____
Address_____
City_____ State_____ Zip Code_____
Home Phone_____ Cell Phone _____
Date of Birth _____ SSN_____ Gender M / F Marital Status _____
Email_____

Emergency Contact

Last Name_____ Relationship_____
First Name_____ Phone_____

Employer

Name_____ Phone_____
Address_____
City _____ State_____ Zip Code_____

Problem

Problem Description _____ Date Symptoms Began _____
Primary Care Physician _____ Date of Last Dr. Visit _____
Motor Vehicle Accident? Y / N Date of Accident _____ State of Accident _____
Surgery? Y / N Date of Surgery _____ Surgeon _____

How did you hear about Dynamic Physical Therapy? _____

All information given above is correct to the best of my knowledge. I give permission to be contacted through all means provided above. I understand that if I choose to communicate through email I am responsible for the security of my personal health information contained in any messages.

Signature _____ Date _____

How would you like to be contacted for your appointment reminders? Please check one box.
☐ Phone: _____ Please circle one: Home Cell Work Other
☐ Text – Phone number (if different from above):_____ Please provide cell service provider (i.e. AT&T):_____
☐ Email: _____

DYNAMIC PHYSICAL THERAPY

CONSENT FOR PHYSICAL THERAPY

1. **COOPERATION WITH TREATMENT:**
   I understand that in order for physical therapy services to be effective I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy.
   I understand that I may be discharged from therapy if I do not keep three (3) appointments without calling to cancel to reschedule and that there is a $25 fee for missed appointments if I do not provide 24 hours notice.
   I understand that it is my responsibility to attend my appointments at the scheduled time and that I may be asked to reschedule if I am more than 15 minutes late for my appointment.
   I agree to cooperate with the home program assigned to me. If I have difficulty then I will discuss it with my therapist.
2. **NO WARRANTY:**
   Dynamic Physical Therapy does not promise a cure for your condition. The treating therapist will provide you with a prognosis for your condition and discuss treatment options with you.
3. **INFORMED CONSENT TO TREATMENT:**
   The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you via the narratives found below. Dynamic Physical Therapy provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition. Treatment may be modified during the course of your care depending on your response to the interventions.
4. **POTENTIAL BENEFITS:**
   Benefits include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility, and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge on how to manage your condition and the resources available to you.
5. **POTENTIAL RISKS:**
   You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is usually temporary and will probably subside within 24 hours. If your symptoms last more than 48 hrs please contact your therapist to let he/she know.
6. **ALTERNATIVES:**
   If you do not wish to participate in physical therapy at Dynamic Physical Therapy then you may discuss your medical, surgical, or pharmacological alternatives with your physician.

I have read or had read to me the foregoing and any questions which may have concerned me have been answered to my satisfaction. I understand the risks, benefits, and alternatives to treatment. Based on this information I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

_____ _____

Patient's Signature Date

_____ _____

Patient's Legal Representative/Guardian/Parent Relationship to Patient

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Financial Agreement

1. **INSURANCE:**
   I authorize and request my insurance company to pay directly to Dynamic Physical Therapy the amount due for services rendered. I understand that it is my responsibility to call my insurance company to verify coverage for physical therapy through my policy, and agree to pay any co-pays, deductibles, and any other portions that my insurance company will not pay at the time of service. As a courtesy to me, Dynamic Physical Therapy will verify my insurance benefits, however, the benefits quoted are not a guarantee of payment. I understand that if my insurance benefits are maxed, denied for not being medically necessary, or if the insurance information I provided is incorrect or invalid I will be billed a private pay fee that is due at the time services are rendered.

2. **PAST DUE ACCOUNTS/COLLECTIONS:**
   In the event payment is not received within 60 days of statement date, my account will be subject to an interest charge of 1 ¾ % per month. If no payment is made, my account will be placed with a collection agency for the amount due as well as collection fees. In the event of default, I agree to pay all collection agency fees in the amount up to 40% of the outstanding balance, and reasonable attorney and court fees.

3. **RETURNED CHECKS:**
   A $20 fee will be applied for all returned checks.

4. **SUPPLY FEES:**
   As part of my care at Dynamic Physical Therapy, treatments might be suggested that have supply fees associated with them. I understand that by giving consent to receive these treatments I agree to pay the associated fees that are explained to me by the therapist before administrating the treatment.

I have read or had read to me the foregoing and any questions which may have concerned me have been answered to my satisfaction. I understand that I am financially responsible for my treatment at Dynamic Physical Therapy and understanding my insurance benefits.

_____ _____

Patient's Signature Date

_____ _____

Patient's Legal Representative/Guardian/Parent Relationship to Patient

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Please refer to the "Privacy Practices Folder" in the waiting room for an explanation of all of your privacy rights as a patient.

I, _____, (please print) acknowledge receipt of a copy of the Notice of Privacy Practices of Dynamic Physical Therapy.

_____ _____/_____/_____

Patient or Personal Representative Signature Month Day Year

*If you would like a copy of your medical record or would like us to send it somewhere on your behalf, please send us a request through writing. Please allow up to 3 business days to process your request. A medical records fee may be applied if the record exceeds 20 pages.

DYNAMIC PHYSICAL THERAPY

Trigger Point Dry Needling (TDN) Consent Form

Trigger point Dry Needling (TDN) 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 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.

TDN is **not** a covered service by insurance companies (including auto insurances and worker's compensation fund). As such, Dynamic Physical Therapy charges a $20 supply fee to cover the cost of the needles. This fee will be due at the time of service.

I am aware of and agree to the TDN supply fee as outlined above.

_____

Signature

Risks 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. The 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 a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection, and nerve injury. 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 do 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.

Please answer the following health questions by circling yes or no:

Do you have any known diseases or infections that can be transmitted through bodily fluids? **YES** **NO**

Are you pregnant? **YES** **NO**

Are you immunocompromised? **YES** **NO**

Are you taking blood thinners? **YES** **NO**

Do you have any cosmetic implants? **YES** **NO**

If you marked yes, please discuss with your practitioner.

_____

Please print your name.

_____ _____

Signature Date

☐ **I was offered a copy of this consent and refused.**

DYNAMIC PHYSICAL THERAPY

What to expect after receiving Trigger Point Dry Needling (TDN)

How will I feel after a session of TDN?

- You may feel sore immediately after treatment in the area of the body where you were treated, this is normal but does not always occur. It can take anywhere from a few hours to the next day before you feel soreness. The soreness may vary depending on the area of the body that was treated. It varies from person to person, but typically feels like you had an intense workout at the gym. Soreness typically lasts 24-48 hours. If soreness lasts longer, please contact your provider.
- It is common to have bruising after treatment; some areas are more likely than others. Some common areas are shoulders, base of neck, head and face, arms and legs. Large bruising rarely occurs but is possible. Use ice to help decrease the bruising, and if you feel concern, please call your provider.
- It is common to feel tired, nauseous, emotional, giggly, "loopy", and/or somewhat "out of it" after treatment. This is a normal response that can last up to an hour or two after treatment. If this lasts beyond a day contact your provider as a precaution.
- There are times when treatment may make your typical symptoms worse. This is normal. If this continues past the 24 – 48-hour window, keep note of it. This is helpful information, and your provider will then adjust your treatment plan based on your report, if needed. However, TDN still may be able to help your condition.

What should I do after treatment, what can I do, and what should I avoid?

- It is highly recommended that you increase your water intake for the next 24 hours after treatment to help avoid soreness.
- After treatment, you may do the following based on your comfort level. If it hurts or exacerbates your symptoms, then stop:
  - Light work out and/or stretch.
  - Massage the area.
  - Use a heating pad.
  - Avoid ice unless you are icing a bruise. Heat is better for muscle soreness.
  - If you are of age you may drink alcohol, but it is recommended you do not do so excessively.
  - Take Tylenol, Ibuprofen/Motrin, aspirin etc. as needed per the recommendation of your physician.

If you are feeling light-headed, having difficulty breathing, chest pain or any other concerning symptoms after treatment CALL us immediately. If you are unable to get a hold of us, call your physician.

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Name: _____ Birthdate: _____ Today's Date _____
Age: _____ Occupation: _____
Height, Weight: _____ Employer: _____
Referring Physician: _____ Date of next appt: _____

Medical/Surgical/Family History:

a – Please put a circle if ***you*** or a box if your ***family*** has ever had:

1 - Arthritis
2 - Heart problems
3 - Stroke
4 - Multiple sclerosis
5 - Seizures/epilepsy
6 - Infectious disease
7 - Depression
8 - Circulation problems
9 - Ulcer
10 - Osteoporosis
11 - Lung problems
12 - Head injury
13 - Cancer
14 - Thyroid problems
15 - Kidney problems
16 - Broken bones
17 - Diabetes
18 - Developmental or growth problems
19 - Blood Disorders
20 - High blood pressure
21 - Allergies
22 - Parkinson disease
23 - Skin disease
24 - Repeated infections
25 - Muscular dystrophy
26 - Low blood sugar

b - Have you ever had surgery? Yes/No
If yes, please describe, and include dates: _____
_____

c – Please circle if you have had any of the following symptoms/conditions in the last year.

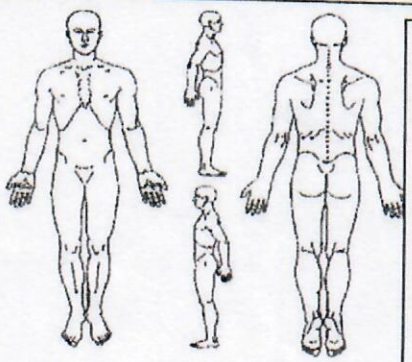
1 – Chest pain
2 – Heart palpitations
3 – Cough
4 – Shortness of breath
5 – Dizziness
6 – Coordination problems
7 – Weakness in arms or legs
8 – Loss of balance
9 – Difficulty walking
10 – Joint pain or swelling
11 – Night pain
12 – Difficulty sleeping
13 – Loss of appetite
14 – Nausea/Vomiting
15 – Bowel or bladder problems
16 - Fever/chills/sweat
17 – Headaches
18 – Hearing problems
19 – Vision problems
20-- Pregnant
21—Depression
22—Highly stressed
23 – HIV or Hepatitis
24 -- _____

Social History:

a – With whom do you live? _____
b – Sleep Patterns: Hours: _____ # times awake/night: _____ Reason for waking: _____
c – Do you use an assistive device for mobility? _____, If so, what? _____
d – Do you smoke? _____ Do you drink alcohol? _____ How many days a week do you exercise? _____
e – How would you rate your health? Excellent Good Fair Poor
f – When was the date of your last complete physical? (month/year/physician) _____

Medication:

Do you take any prescription or non-prescription medications? Yes/No
If yes, please list: _____



Current Condition/Chief Complaint

Mark areas on the drawing to the Left where you feel the described sensations. Include all affected areas.

Please indicate on a scale of 0-10 what your current pain level is: _____/10. What is the worst your pain gets to? _____/10
What are we seeing you for? _____
When did this problem/pain begin? _____
How did this problem begin? _____
What are your goals for therapy? _____

Patient's Signature: _____ **Date:** _____