FX PHYSICAL THERAPY

Name: _____ **Primary Care Physician:**_____

Have you RECENTLY noted any of the following (check all that apply)?

❑ changes in appetite
❑ changes in bowel or bladder function
❑ difficulty maintaining balance while walking
❑ difficulty swallowing
❑ dizziness/lightheadedness
❑ fever/chills/sweats
❑ headaches
❑ nausea/vomiting
❑ pain at night
❑ short of breath
❑ weakness/fatigue
❑ weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ anemia
❑ asthma
❑ cancer (type)_____
❑ chemical dependency (i.e., alcoholism)
❑ depression
❑ diabetes
❑ epilepsy
❑ heart disease
❑ high blood pressure
❑ kidney/liver problems
❑ lung problems
❑ multiple sclerosis
❑ osteoporosis
❑ pacemaker inserted
❑ Parkinson's disease
❑ rheumatoid arthritis
❑ stomach ulcers
❑ stroke
❑ thyroid problems
❑other_____
❑other_____

Do you smoke? YES NO _____ pack/day
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list current medications:_____ Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**

ALLERGIES: _____ Are you latex sensitive? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _____ 2._____ 3._____

Pain at LOWEST: Rate your lowest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain now.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

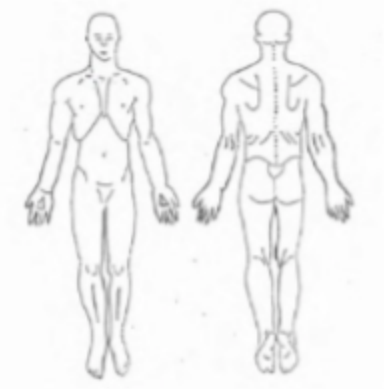
Pain at WORST: Rate your highest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
=== Burning



How did you hear about us?_____
Patient Signature:_____ **Date:**_____

PATIENT CONSENTS AND RELEASES
Revised 03.2017

FX PHYSICAL THERAPY

Please read carefully before you sign. Your signature acknowledges understanding of all items set forth herein. If you have questions regarding any sections, please ask the assigned outpatient representative for assistance.

☐ Consent to Medical and Therapeutic Services

I consent to the procedures, which may be performed during the duration of this outpatient treatment, including emergency treatment. I understand that if I fail to carry out the follow-up medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care or may provide care as a part of their education. I also understand that the rehabilitation process, by its very nature, involves certain inherent unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation altogether.

☐ Photograph/Video Consent Release

I hereby give FX PHYSICAL THERAPY the absolute right and permission to copyright, publish, and/or use pictures, video, audio recording or written statement/testimonials of me, or reproductions thereof, in color or otherwise, made through any media at our offices or elsewhere, for art, advertising, trade, research or any other lawful purpose whatsoever.

☐ Financial Agreement/Guarantee of Payment and Assignment of Benefits

I request that payment of authorized by Blue Cross Blue Shield and/or other benefits be made on my behalf to FX PHYSICAL THERAPY. I authorize FX PHYSICAL THERAPY, if it chooses, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. FX PHYSICAL THERAPY, its agents and employees are hereby released from any and all liability of any nature that may arise from the release of information. I guarantee the payment of the full and entire allowed amount of all bills for services rendered for the patient. Any self-pay amounts not paid within forty-five (45) days of any notice of non-payment shall be subject to progressive collection activities up to and including referral to an independent collection agency. I also understand that all insurance coverage quoted to me and/or responsible parties are estimated and final determination of benefits and coverage lies with my insurance company. I certify that I have disclosed any and all health insurance coverage information and I agree to provide FX PHYSICAL THERAPY with any changes in my insurance coverage in a timely manner. I understand that as a courtesy and based on the information I provide; FX PHYSICAL THERAPY will attempt to verify my insurance benefits. I understand that verification is never a guarantee of payment. I am responsible for payment of all co-pays and coinsurance estimates at the time of service and that these estimates may be high than those for my primary care physician. Once my insurance company has processed claims, if the amount collected at the time of service was not enough to cover my portion, I may be billed in addition to cover my portion. Likewise, if the estimate I paid was more than my portion, I may be entitled to a refund. After 90 days of billing any secondary payer, unpaid coinsurance may become my responsibility.

☐ Managed Care Plan Obligations

I understand that my insurance carrier may require me to have a current and complete written referral from my primary care physician (in some instances the referring physician may be able to provide it). I understand that FX PHYSICAL THERAPY recommends I check with my carrier directly. If a referral is required and is not presented prior to my treatment being rendered, my insurance may not cover all or a portion of the medical expenses incurred. In this instance, I am responsible for all uncovered charges. It is my responsibility to assist the FX PHYSICAL THERAPY staff in obtaining addition referrals when necessary and appropriate. Should I require additional or more specific information regarding my insurance coverage, I will contact my carrier directly.

☐ Appointment Reminders (Physician services only)

I authorize FX PHYSICAL THERAPY to send appointment reminders to me via email.

Email Address: _____

FX PHYSICAL THERAPY

FUNCTIONAL DRY NEEDLING® CONSENT AND REQUEST FOR PROCEDURE

Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective All training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure.

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

Risks: The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If you ever feel symptoms of shortness of breath or develop an unexplained cough please contact us. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Procedure: I, _____, authorize FX Physical Therapy to perform Functional Dry

Needling® as part of my physical therapy treatment.

Please answer the following questions:

Are you pregnant? Yes No **Are you immunocompromised?** Yes No **Are you taking blood thinners?** Yes No

DO NOT SIGN UNLESS YOU HAVE READ & THOROUGHLY UNDERSTAND THIS FORM.

You have the right to withdraw consent for this procedure at any time before it is performed.

_____ _____ _____

Patient or Authorized Representative Date Time

_____ _____

Relationship to patient (if other than patient) (Patient name printed)

FX PHYSICAL THERAPY

Notice of Privacy Practices

Receipt/Waiver Documentation Form

In compliance with federal regulations, we are required to distribute the FX Physical Therapy "Notice of Privacy Practices" to all patients.

Option 1: If you wish a printed copy of the privacy practices, please sign below and a Team Member will provide one

- I request a printed copy of the FX Physical Therapy "Notice of Privacy Practices"

Patient Name (please print)

Patient Signature Date

Option 2: If you wish to **waive** receipt of a printed copy of the privacy practices, please sign below.

- I have been offered the FX Physical Therapy "Notice of Privacy Practices" and waive receipt of a printed copy.

Patient Name (please print)

Patient Signature Date