FOREVER FIT
Physical Therapy

Thank You for choosing Forever Fit Physical Therapy for your physical therapy needs. In order to treat you the best we can, all information requested below must be completed. Leaving information incomplete or blank may result in a denial in coverage or payment by your insurance company.

Patient Information

Name:	Date of Birth:
Mailing Address:	Social Security Number:
City:	E-mail Address:
State:	Work Phone:
Zip:	Home Phone:
□Male □Female	Cell Phone:
□Single □ Married □Widowed □Student □Divorced	Emergency Contact Name & Phone #:
Referring Physician:	Date of Injury:

Patient Employer Information

Employer name:	Occupation:
Address:	
City/State/Zip:	

Primary Insurance Information **Self Pay? □Yes □ No**

Insurance Carrier:	Insured Employer:
Insured Name:	Insured Date of Birth:
ID #	Group #
Insured SS#:	Supplement policy:

Work Related? □Yes □ No **Motor Vehicle Accident Related? □Yes □ No**

How did you find out about Forever Fit?

□Internet □Newspaper □Yellow pages □ Physician □Friend □Other

Notice of Privacy Practices/HIPAA policy

DUE TO FEDERAL PRIVACY RULES (HIPAA) we cannot speak to anyone but yourself regarding your treatment or bill without your consent. Please indicate the person(s) that you are authorizing us to release your personal protected health information to:

_____ Person _____Relationship to Patient

_____ Person _____Relationship to Patient

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up care among the multiple health care providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide in such restrictions.

TO STUDENT ATHLETES: I authorize the athletic training staff, team physicians, school nurse, and athletic staff to have access to information and to provide any and all care deemed necessary for any specific injury or condition and to release any medical information necessary. By signing below, I hereby authorize the above parties to release and share any necessary information needed to treat a specific injury or condition, whether pre-existing or acute.

Reminders: As a courtesy, Forever Fit has an appointment reminder system, please choose one:

- ☐ Forever Fit Physical Therapy may send email messages to confirm my upcoming appointments. Please enter email_____
- ☐ Forever Fit Physical Therapy may send cell phone text messages to confirm upcoming appointments (I recognize that normal text message rates may apply)
    - Phone number_____ Cell Provider_____

Patient's Signature (parent, if minor):_____ Date:_____

Please Print Name: _____

Informed Consent and Physical Therapy Policies

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Forever Fit Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. It is also your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

Initial _____

<u>Insurance Benefits:</u>

All patients are required to know their Physical Therapy benefits. As a courtesy Forever Fit will call to verify, however, this is not a guarantee of benefits or payment. What the company tells us can be denied or changed during and after the payment cycle. You are responsible for all denied claims. I understand that I am responsible to giving Forever Fit any change of information with my insurance coverage. I authorize my insurer to pay any benefits for services rendered directly to Forever Fit. I understand that anything not covered by insurance is my full responsibility.

Initial _____

<u>Payment:</u>

All Co-pays and balances are due at the time of service. Initial _____

<u>Interest Charges:</u>

Forever Fit will charge interest on all unpaid patient balances past 30 days. The charges are as follows:

31 to 60 days 10%

61 to 90 days 15%

91 and beyond 20%

Compounded Monthly Initial _____

<u>Cancellation/No Show Policy:</u>

Cancellation without 24 hr. notice $75.00 fee Initial _____

No Show Fee $150.00 Initial _____

Patient's Signature: _____ Date:_____

Please Print Name: _____

Patient Health Information

NAME:_____ DATE OF BIRTH_____

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? Yes No List any other allergies we should know about:

How would you rate your overall health: Excellent Good Fair Poor

Medical History:						In the past 3 months:		
Arthritis/Gout	Yes	No	Infectious Disease	Yes	No	Nausea/vomiting	Yes	No
Blood disorder	Yes	No	Kidney/Liver disease	Yes	No	Fever/Chills/Sweats	Yes	No
Cancer	Yes	No	Lung Disease	Yes	No	Unexplained weight change	Yes	No
Circulation Problems	Yes	No	Migraines	Yes	No	Change of Appetite	Yes	No
Coronary Heart Disease	Yes	No	Multiple Sclerosis	Yes	No	Difficulty swallowing	Yes	No
Depression	Yes	No	Osteoporosis	Yes	No	Changes in Bowel or bladder function	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No	Shortness of breath	Yes	No
Epilepsy/Seizures	Yes	No	Panic attacks/ Anxiety	Yes	No	Dizziness	Yes	No
Fibromyalgia	Yes	No	Pregnant (currently)	Yes	No	Upper respiratory infection	Yes	No
Head injury	Yes	No	Parkinson's Disease	Yes	No	Urinary tract infection	Yes	No
Hearing problems	Yes	No	Stomach Disease/Ulcer	Yes	No	Changes in balance	Yes	No
High cholesterol/lipids	Yes	No	Stroke/Paralysis	Yes	No	Fatigue/weakness	Yes	No
Hospitalization- past	Yes	No	Thyroid Disease	Yes	No	Double vision/loss of vision	Yes	No
Hypertension	Yes	No	Visual Problems	Yes	No	Allergies/asthma	Yes	No
Learning Disability	Yes	No	Lupus	Yes	No	Pneumothorax	Yes	No
Immunocompromised	Yes	No	Neurological conditions	Yes	No			

Are there any other medical conditions (not listed above):_____
Surgeries (Date and Reason):_____
_____
Do you or have you ever smoked tobacco? If yes, _____packs/day x years Last tobacco use _____

Prescribed Medications: _____
Are you taking any light sensitive medications: Yes No
Are you taking any blood thinners Yes No
Over the counter medications:
___ Aspirin ___ Tylenol ___ Advil/Aleve/Ibuprofen ___Antacid
___Laxatives ___ Decongestants ___Vitamins/Minerals Other _____

Patient's Signature: _____ Date:_____

Please Print Name: _____

Pain Diagram and Pain Rating

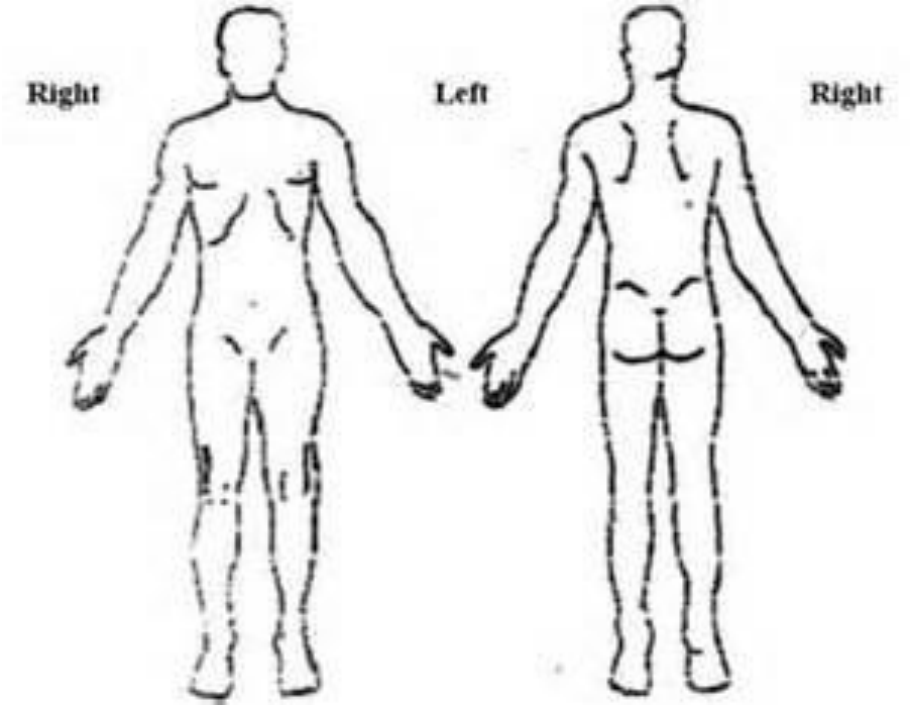
Name_____

Date of Injury:_____

How did injury happen:_____

_____

Please use the diagram below to indicate the symptoms you have experienced.



Key: Pain= XXXXXXX Numbness or Pins and Needles= OOOOOOOOOOO

Please rate your **current level of pain** on the following scale: (circle one) 0= no pain, 10= worst imaginable pain

0 1 2 3 4 5 6 7 8 9 10

Please rate your **least amount of pain** on the following scale: (circle one) 0= no pain, 10= worst imaginable pain

0 1 2 3 4 5 6 7 8 9 10

Please rate your **worst level of pain** on the following scale: (circle one) 0= no pain, 10= worst imaginable pain

0 1 2 3 4 5 6 7 8 9 10

Are your symptoms:

_____ Getting worse _____ Staying the same _____Improving

How much are your symptoms affecting your activities of daily living?

_____Extremely _____Moderately _____Little _____None

What are your symptoms **Limiting** in your life?

_____

_____

What are your **Goals** for physical therapy?

_____

_____

Patient's Signature: _____ Date:_____

Please Print Name: _____

Informed Consent for Light Force Deep Tissue Therapeutic Laser

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment. Effects of your treatment will continue for up to 30 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results. Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

Laser Therapy is not covered by commercial insurance, except worker compensation. I understand there is an extra fee for services that are posted in the front of the office.

☐ I understand the above and consent to treatment

☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

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. Your physical therapist trained by KinetaCore® has met the requirements for **Level 2** ***(54 hours of training)*** competency in FDN® and is now considered a certified Functional Dry Needling® Practitioner. 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: Bruising is a common occurrence and should not be a concern. The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely 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 puncture can require hospitalization and re-inflation of the lung. 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.

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 will 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 Erin Rosso DPT, ATC, CSCS to perform Functional Dry

Needling® for my diagnosis of _____.

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's Signature: _____ Date:_____

Please Print Name: _____