This information is strictly confidential. Your answers will help us determine if physical therapy can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please be as accurate as possible. If you do not understand a question, please ask your therapist for assistance.

MEDICAL HISTORY HEALTH FORM
If you do not understand a question, please ask your therapist for assistance.

Your Name: _____ **Date**: _____**DOB**:_____

Describe the problem you are seeing the physical therapist for:_____

_____

When did you first notice symptoms? _____

_____

Please rate your pain on a 0-10 scale (1 is very mild pain, 10 is the worst imaginable pain):

1 2 3 4 5 6 7 8 9 10

Please circle/describe your symptoms:

Constant (24 hours/day)	Burning	Numbness
Intermittent (comes and goes)	Pins and Needles	Throbbing
Knife-like/ Sharp	Dull/aching	
Other: _____		

Have you seen a physical therapist or had other treatments for this within the past year? _____

_____

Referring Physician: Date of Next Follow-up: _____

Leisure Activities: _____

Have you ever been diagnosed with any of the following? If "Yes", please explain in the space provided.

Disease Processes:

Cancer	No	Yes_____
Diabetes Mellitus	No	Yes_____
High Blood Pressure	No	Yes_____
Arthritis	No	Yes_____
Osteoporosis	No	Yes_____
Seizures	No	Yes_____
Coronary Artery Disease	No	Yes_____
Heart or Vascular Diseases	No	Yes_____
Neurological diseases	No	Yes_____

Current Health/Medical Conditions:

Do you have chest pain (angina)?	No	Yes _____
Do you have a Pacemaker or electrical implant?	No	Yes_____
Do you have breathing problems?	No	Yes_____
Do you have frequent headaches/migraines?	No	Yes_____
Unexplained nausea/vomiting?	No	Yes _____
Unexplained fever, night sweats?	No	Yes_____
Does pain wake you from sleep?	No	Yes_____
Changes in bowel and bladder function?	No	Yes_____
Dizziness/vertigo?	No	Yes_____
Numbness and tingling?	No	Yes_____
Urinary tract infection (less than 1 month ago)?	No	Yes_____
Osteoporosis	No	Yes _____
Are you currently pregnant?	No	Yes_____
How many weeks?_____		
Menstrual irregularities?	No	Yes_____
Taking Birth Control	No	Yes_____
Difficulty swallowing?	No	Yes_____
Weight Loss/Gain?	No	Yes_____
Changes in appetite?	No	Yes_____
Fatigue?	No	Yes_____
Weakness?	No	Yes_____
Fever/chills/sweats?	No	Yes_____
Depression?	No	Yes_____

Social History:

Tobacco use?	No	Yes_____
Have you recently suffered trauma from a fall, car Accident, sports, etc?	No	Yes_____Date:_____
Difficulty hearing?	No	Yes_____
Speech problems?	No	Yes_____
Vision problems?	No	Yes_____

Please describe any <u>injuries and/or surgeries</u> for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:_____
_____

Please list any <u>Non-prescription and Prescription</u> medications that you are currently taking (including pills, injections or skin patches):

_____

What are your goals for physical therapy?_____

_____

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Embody
ORTHOPEDIC & SPORTS PHYSICAL THERAPY

Dry Needling Consent & Information Form

What is Dry Needling?
Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in the muscle), tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low back pain.

Is Dry Needling Safe?
Drowsiness, tiredness, or dizziness occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly after the first treatment session when needling the head or neck regions. Dry needling is very safe; however serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000).

Is there anything your practitioner needs to know?

1. Have you ever fainted or experienced a seizure? Yes/No
2. Do you have a pacemaker or any other electrical implant? Yes/No
3. Are you currently taking anticoagulants (blood-thinners eg Warfarin, Coumadin)? Yes/No
4. Are you currently taking antibiotics for an infection? Yes/No
5. Do you have a damaged heart valve, metal prosthesis, recent surgery (within the past 3-6 months), or other risk of infection? Yes /No
6. Are you pregnant or actively trying for a pregnancy? Yes/No
7. Do you suffer from metal allergies? Yes/No
8. Are you a diabetic or do you suffer from impaired sensation or wound healing? Yes/No
9. Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? Yes/No
10. Have you eaten in the last two hours? Yes/No
11.

***Only single-use, disposable needles are used in this clinic**

STATEMENT OF CONSENT
I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I understand that I can refuse treatment at any time.

Signature: _____ Date: ___/___/_____

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PATIENT CONTACT INFORMATION

Patient Name: _____DOB: _____

Address: _____City: _____ State: ____ Zip: _____

Home Phone: _____Cell Phone: _____

Email:_____ Marital Status: **S / M / D / W** Sex: **F or M**

If under 18yrs old, name/phone number of Parent or Guardian: _____

Emergency Contact Name: _____Phone: _____

Primary Care Physician: _____

INSURANCE INFORMATION

Company: _____ Subscriber ID: _____

Subscriber's Name (if different from patient):_____

Subscriber's DOB: _____

APPOINTMENT REMINDERS

Would you prefer to receive **email** or **text** reminders?_____

If text reminders, who is your phone carrier (ie Verizon, Att&t)? _____

ACKNOWLEDGMENT OF OFFICE POLICIES

The following are Embody Orthopedic & Sports Physical Therapy's polices for billing, cancellations, consent, and release of information. Please read carefully and ask if you have any questions.

Informed Consent: I, the undersigned, give Embody Orthopedic & Sports Physical Therapy my permission to perform a full evaluation and treatments as necessary. It is your right to accept or refuse any treatment offered. I understand the term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand I will receive education concerning the diagnosis, treatment and prognosis including anticipated goals at the initial visit. I will also be explained my plan of treatment and the options available for my condition at that time.

Use and Disclosure of Your Health Information/Privacy Practices Patient Acknowledgement: Your health information will only be used or disclosed by Embody Orthopedic & Sports Physical Therapy for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice including any administrative operations related to treatment or payment.

--Email—Embody OSPT may use my email to contact referring physician or medical assistants of the referring physician to discuss medical history or treatment options as well as send occasional company newsletters containing relevant medical/rehab news and updates, deals or promotions. Email addresses will never be used by or given to 3rd parties for use outside of Embody OSPT. All email correspondence will comply with all HIPAA requirements.

Authorization to Release Information: I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

Patient Request for Records: I authorize the release of all pertinent medical, hospital, or surgical records to Embody Orthopedic & Sports Physical Therapy.

Cancellation policy: Embody Orthopedic & Sports Physical Therapy understands that there are times when you may need to cancel or reschedule your appointment. Please provide 24 hour notice in order to avoid a cancellation fee of $50.00. It is your job as a patient to attend appointments in order to get better. If you miss/cancel 3 appointments, you will be discharged from care. If you cancel 2 appointments, you will no longer be allowed to schedule in advance and must book appointments on a week-by-week basis based on availability.

Insurance Benefits and Payment: Embody Orthopedic & Sports Physical Therapy is currently accepting insurance from BCBS, Blue Choice (including Blue Options/Blue Essentials), BCBS State/Federal, Cigna, UnitedHealthcare, Aetna, AARP Medicare Complete, Medcost, and Medicare. For all other insurance companies, we are currently out-of-network, and, in those cases, we are a pay-for-service practice. You will be expected to pay for the services provided following the conclusion of each session.

- **Deductible**: For patients paying into their deductible, we collect $70 at the time of service; it is our office policy to wait for a remittance from the insurance company specifying remaining patient responsibility. This amount is billed on a monthly basis.
  Please take note, each visit will roughly cost between $70-115; this amount is decided by your insurance company and their set fee-schedule.

- **Coinsurance**: For patients with a 10% coinsurance, we collect $5 at the time of service.
  Patients with 20% coinsurance, we collect $10.
  We wait on a remittance from the insurance company to specify the remaining patient responsibility. This amount is billed on a monthly basis.

- **Postoperative**: Patients who exceed their maximum allowable visits/max allotted amount per insurance plan, will be responsible for our self-pay rate of $70 per visit.

- **Cash-based:** $110 for initial evaluation and $80 per follow-up visit. This amount is due at the time of service.

Assignment of payment: I hereby authorize my insurance company and/or my attorney to pay direct to Embody Orthopedic & Sports Physical Therapy any monies due on my account for professional services rendered.

Payments for Services: It is further understood that I, the undersigned, will be responsible for the full amount of the charges should my treatment sessions not be covered by insurance. I also understand that I am responsible for whatever fees my insurance company does not pay on my claim (e.g. co-payments or deductibles).

Equipment Charge: At your initial evaluation you will be charged a **$10** fee for any/all equipment that may be used for you or given to you throughout your care (i.e. kinesio tape, dry needles, bands, etc).

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: _____ Date: ___/___/_____

Name (Please Print): _____

Embody Orthopedic & Sports Physical Therapy Privacy Notice Acknowledgement

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy practices. You have the right to review that notice before you sign this acknowledgment form. We encourage you to read this document carefully as it details the limitations of use and disclosure of your personal and/or health information and your rights as a patient.

As always, we are happy to address any questions you may have regarding the use of this information.

I acknowledge that I understand the contents of the Embody Orthopedic & Sports Physical Therapy Notice of Privacy Practices for Protected Health Information.

Signature: _____ Date: ___/___/_____

Cancellation Policy

At Embody Orthopedic & Sports Physical Therapy, we strongly encourage you to attend all scheduled visits in order to maximize your results during rehabilitation. In the event that you are unable to attend an appointment, **24-hour notice is required**.

If you are unable to provide notice (notice given under 24 hrs), a $50 fee will be charged to you. Three (3) cancellations/no shows during a plan of care will result in early discharge from treatment. If you cancel two (2) appointments, you will no longer be allowed to schedule in advance and must book appointments on a week-by-week basis, based on availability.

We appreciate your commitment to this process and will work hard to help you achieve your goals.

I understand the cancellation policy. I am committed to reaching my goals.

Signature: _____ Date: ___/___/_____

COVID-19 QUESTIONNAIRE

Have you been around anyone who has had/been exposed to COVID-19 in the past 14 days? **Yes** **No**

Have you worked in facilities or locations with recognized COVID-19 cases? **Yes** **No**

Do you have any of the following (please circle if apply):

fever or chills **shortness of breath/difficulty breathing** **new loss of taste or smell** **cough**
body aches **headache** **sore throat**

Please list your travel history (if any) in the past month? _____

Signature: _____ Date: ___/___/_____

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