TERMS OF ACCEPTANCE AND CONSENT TO TREATMENT

Compliance with your physical therapy appointments is very important for your recovery.
Please take full advantage of your physical therapy sessions by arriving on time. Please notify us if you are going to be more than 10 minutes late. You may need to reschedule your appointment. If you fail to meet 3 consecutive appointments, we will notify your doctor and employer (if applicable) and you may be discharged from our care.

There will be a **$50.00 charge** for missed appointments not canceled with 24-hour notice prior to the appointment. (*Refer to CC Auth Form)* _____ (Initial)

The information obtained from your insurance company is a quote of benefits, not a guarantee. Your Explanation of Benefits (EOB) will determine your ultimate financial responsibility. _____ (Initial)
Once these benefits have been determined, payments of any copays or annual deductibles are required at the time services are rendered. _____ (Initial)

HIPPA compliance and health privacy information can be found at https://www.hhs.gov/hipaa
I have read and I understand the information above and I agree to comply.

Signature: _____ Date: _____

It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever it is he/she is suffering from; latent pathological defects, illnesses or deformities that would otherwise not come to the attention of the treating practitioner. The treating practitioner provides a specialized, non-duplicating health care service, and furthermore, any risk involved regarding physical therapy will be explained to you upon your request. Your treating practitioner is licensed in a special practice and is available to work with other types of physicians, practitioners and providers in your health care regimen.

Consent to Treat:

I, _____ give consent to the staff of Busybody Fitness & Rehab to treat me for physical therapy services that will be rendered.

Signature: _____ Date: _____

Consent to Evaluate and Treat a Minor

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant authorization for my child to receive physical therapy services.

Signature: _____ Date: _____

Name: _____

Patient Demographic Information

Address:_____ City/State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Age:_____ Date of Birth:_____ Sex:_____ Marital Status:_____

Social Security Number: _____ Driver's License Number: _____

Referring Physician:_____ Phone:_____

If patient is a minor, name of parent/guardian:_____

Email Address: _____

Employer: _____ Occupation: _____

Employment Information

Employer's Address: _____

Employer's Phone: _____ Email Address: _____

Emergency Contact

Name: _____ Relationship:_____ Phone:_____

If policy holder's information is different than above, please fill out the following information

Policy Holder's Name: _____

Relationship to Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder's SSN _____

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Cell Phone:_____

Primary Insurance Information

Insurance Company:_____

Claim's Phone #:_____Policy Number: _____

Group Number: _____

Secondary Insurance Information

Insurance Company:_____

Claim's Phone #:_____Policy Number: _____

Group Number: _____

PROFESSIONAL SERVICES MUST BE PAID AT THE TIME THEY ARE RENDERED.

Assignment of benefits: I hereby authorize payment directly to Busybody Fitness & Rehab of benefits due for physical therapy services rendered. I understand I am financially responsible for charges not covered by this authorization.

Release of information: I hereby authorize Busybody Fitness & Rehab to release any information required to process this claim form.

Patient Signature _____ Date _____

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Medical History Form

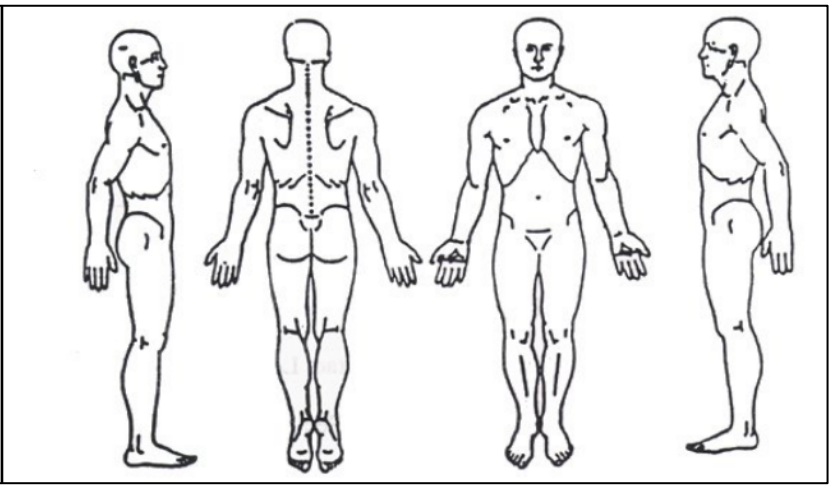
Patient Name: _____ DOB: ___/___/____ Diagnosis or Problem Area:_____

Describe the problems or limitations you are having now. _____

_____

What activities aggravate your injury / problem area? _____

What activities relieve your injury / problem area? _____

Pain Diagram: Use symbols below to mark diagram **Description:** ^^^ = Aching /// = Numbness >>> = Stabbing xxx = Burning 000 = Pins / Needles +++ = Throbbing **Is the pain getting:** □**Better** □**Worse** □**No Change**	

List your medications (attach list if needed):

_____

_____

_____

Please check as many of the following conditions that apply to you. Are you currently or have you ever experienced the following:

□Chest Pain
□Heart Attack
□High Blood Pressure
□Low Blood Pressure
□Tuberculosis
□Imbalance / Frequent Falls
□Bleeding / Bruising Problem
□Blood Clots
□Respiratory Disease
□Smoking
□Head Injury
□Visual/hearing impairment
□Stroke
□Pace Maker
□Blackouts
□Arteriosclerosis
□Dizziness
□Poor Circulation
□Cancer
□Severe Night Pain
□Night Sweats
□Osteoporosis
□Diabetes
□Numbness to Hands or Feet
□Seizures
□Osteoarthritis
□ High Blood Cholesterol (Hyperlipidemia)
□Rheumatoid Arthritis
□Skin Rash / Disease
□HIV / AIDS
□Hepatitis
□Difficulty Breathing/Shortness of Breath
□Pregnancy
□Bowel / Bladder Problems

Rate your pain from 0-10 as follows:

0-1 No Pain
2-3 Mid Pain
4-5 Moderate/Discomforting
6-7 Distressing/Severe Pain
8-9 Intense/Very Intense
10 Severe/Unbearable

Now: _____ **At its Best:** _____ **At its Worst:** _____

I certify, to the best of my knowledge that the above information is complete and true. If my medical health status changes, I will inform a member of the Busybody Fitness and Rehab Staff immediately.

Patient Name (Please Print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent Consent to Treat a Minor (for patients under the age of 18)

Being the parent or legal guardian of _____(minor's printed name), I _____ (parent/guardian printed name) hereby authorize Busybody Fitness and Rehab, PLLC to perform physical therapy evaluation and/or treatment of the above mentioned minor.

Minor's Date of Birth: _____

Parent/Legal Guardian Signature _____ Date _____

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Photography Consent/Release

I, _____, herby grant permission to Busybody Fitness & Rehab representatives, to take and use: photographs, videos, and / or digital images of me for use in news releases and / or educational materials. These materials might include printed or electronic publications, websites, or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, and digital reproductions shall be the property of Busybody Fitness ad Rehab.

Patient Signature: _____ **Date:** _____

I, _____, parent or official guardian of

(child's name) _____ herby grant permission to Busybody Fitness & Rehab representatives, to take and use: photographs, videos, and / or digital images of my child for use in news releases and / or educational materials. These materials might include printed or electronic publications, websites, or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, and digital reproductions shall be the property of Busybody Fitness & Rehab.

Parent/Guardian Signature: _____ **Date:** _____

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Dry Needling Consent & Information Form

Dry needling involves inserting a tiny monofilament needle in a muscle(s) 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. Dry needling 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 dry needling 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 anywhere from 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.

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; 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.

Please answer the following questions:

1. Have you ever fainted or experienced a seizure? ☐Yes ☐No
2. Do you have a pacemaker or any other electrical implants? ☐Yes ☐No
3. Are you currently taking anticoagulants (ex: Aspirin, blood thinners)? ☐Yes ☐No
4. Are you currently taking antibiotics for an infection? ☐Yes ☐No
5. Do you have a damaged heart valve, metal, or other risk of infection? ☐Yes ☐No
6. Are you pregnant? ☐Yes ☐No
7. Do you suffer from metal allergies? ☐Yes ☐No
8. Are you diabetic or do you suffer from impaired wound healing? ☐Yes ☐No
9. Do you have Hepatitis B, C, HIV, or any other infectious disease? ☐Yes ☐No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM. You have the right to withdraw consent for this procedure at any time before it is performed. Dry Needling is not covered by insurance. As a procedure by itself, the cost is $300 for the initial visit, with following sessions of $120 for one body part or $150 for multiple body parts (therapist discretion), and $65 as a procedure with physical therapy insurance visit. _____ (Initial)

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Authorized Representative Date

Physical therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

_____ _____
Physical Therapist Date