Medical History/Patient Information

Name _____ Primary Phone (_____) _____ Secondary Phone (_____)_____

Address_____
Street *City* *State* *Zip*

Male____ Female ____ Birthdate _____ Single____ Married ____ Separated ____ Divorced ____Widowed_____

Employed by_____ Occupation_____

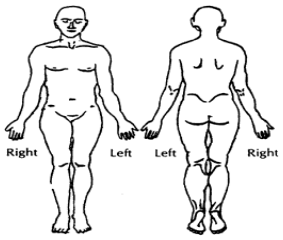
How did you hear about us? _____ Referring Doctor _____

Emergency Contact_____ Relationship _____ Phone Number (_____) _____

Chief Complaint (explain) _____
_____
_____
_____

Date of Onset_____
Pain Level 1 2 3 4 5 6 7 8 9 10
Medications (List) _____
_____
_____

Indicate on Diagram where the pain is:



Do you have or have you had any of the following? Please circle which symptom if listed with others.

_____Heart Condition (heart attack, chest pain, etc.)
_____Stroke or TIA
_____Blood Clot or Embolus
_____High or Low Blood Pressure
_____Respiratory Condition (asthma, emphysema, shortness of breath, etc.)
_____Epilepsy or Seizure
_____Infectious Disease (AIDS/HIV, Hepatitis, etc.)
_____Diabetes
_____Cancer or Chemo/Radiation
_____Decreased appetite, fever, night sweats, or unexplained weight loss
_____Thyroid Condition
_____Any Implants (pins, metal, pacemaker, breasts, etc.)
_____Arthritis

_____Osteoporosis
_____Neurological Condition
_____Bowel or Bladder Condition
_____Pregnancy
_____IUD (women only)
_____Gout
_____Difficulty Sleeping
_____Headaches
_____Hernia
_____Emotional or Psychological Condition
_____Allergies
_____Any Surgery for Any Condition

Please explain any items you checked above: _____
_____
_____

Do you have or have you had any of the following?

_____ Neck Injury _____ Shoulder Injury _____ Wrist or Hand Injury _____ Knee Injury
_____ Back Injury _____ Elbow Injury _____ Hip or Pelvis Injury _____ Ankle or Foot Injury

Please explain any of the above injuries or conditions: _____
_____
_____

The above information is true to the best of my knowledge. I hereby assign all medical benefits for which I am entitled to CC's Physical Therapy in the event they file insurance claims on my behalf. I understand I am responsible for all charges whether or not paid by insurance. In the event my account becomes delinquent and is therefore in default of payment; I accept responsibility for the principal amount. Interest may be charged in the amount of 18% each month for unpaid balances over 90 days delinquent. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of CC's Physical Therapy for my condition as described above. This consent is intended as a waiver of liability for such treatment except in acts of negligence.

Signature (Guardian <18) _____ Date _____

Intramuscular Manual Therapy aka Trigger Point Dry Needling (TDN) Consent Form

IMT / TDN involves placing a small needle into the muscle at the trigger point which is typically in an area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.

IMT / TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like any treatment there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

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 as it can resolve on its own. The symptoms of pain and 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. If you feel any related symptoms, immediately contact your IMT / TDN provider. If a pneumo is suspected you should seek medical attention from your physician or if necessary go to the emergency room.
Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. 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 IMT / TDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Please answer the following question by circling yes or no:
Do you have any known disease or infection that can be transmitted through bodily fluids?

YES NO *If you marked yes, please discuss with your practitioner.

_____	_____	_____
Print your name	**Signature**	**Date**

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

CC's Physical Therapy No-Show Policy

***Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.**

Definition of a "No-Show" Appointment

CC's Physical Therapy defines a "No-Show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than a 2 hour notice
- Arrives more than 15 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No Show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- It is unfair to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "No-Show"

- Confirm your appointment
  *CC's Physical Therapy is not responsible to contact you before your scheduled appointment to confirm your visit. It is the patient's responsibility to call and confirm their appointment time. Since CC's Physical Therapy provides appointment cards, we are not required to call the patient.
- Arrive 5-10 minutes early
  *When you schedule an office visit with us, we expect you to arrive at our facility 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions, complete any necessary paperwork and or to collect a copay before the scheduled visit.
- Give a 2 hours' notice if you need to cancel
  *When you need to cancel or reschedule a scheduled visit, we expect you to contact our office no later than 2 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 2 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

For every no-show the patient has, they will **automatically be billed a $35 fee** for each date of service that they no-show for. If the patient continues to no-show at least three times, the patient may be dismissed from CC's Physical Therapy at the discretion of your Physical Therapist.

I have read and understand the CC's Physical Therapy "No-Show" Policy as described above.

_____ _____

Patient Signature **Date**

CC's Physical Therapy

Notice of Patient Information Practices

Please initial after every bold heading and sign at the bottom upon agreement

CC's Physical Therapy Legal Duty:

The Company is required by law, to protect the privacy of your personal health information, provide this notice about our practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

CC's Physical Therapy uses your personal health information primarily for treatment, obtaining payment of treatment, conducting internal administrative activities, and in evaluating the quality of care we provide. For example we may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

CC's Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, auditing purposes, and emergencies. We may provide de-identified information for research studies. We may also provide information as required by law.
In any other situations, we are to obtain your written authorization before disclosing your personal health information. If you choose to provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

CC's Physical Therapy may change its policy at any time. When changes are made a new Notice of Patient Information Practices will be posted in a common area of our Bismarck Clinic. You may also request an updated copy of the practices at any time.

Patient's Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.
You may also request in writing we do not use or disclose your personal health information for treatment, payment, and administrative operations except when specifically authorized by you. These requests will be considered on a case-by –case basis, but the company is not legally required to accept them.

Concerns and Complaints

If you are concerned that CC's Physical Therapy may have violated your privacy rights, or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the company owner, April Neshem. You may also send a written complaint to the US Department of Health and Human Services.

I have read and am in agreement of the above policies and have received a copy of the Notice of Patient Information Practices. I consent to the use and disclosure of my personal health information for puposes as noted in the Notice of Patient Information Practices. I understand I retain the right to revoke this consent by notifying the Company in writing at any time.

_____ _____ _____

Patient Signature and Guardian Signature if Under 18 Name Printed Date

CC's Physical Therapy

FINANCIAL POLICY STATEMENT

We bill your insurance carrier as a courtesy to you. If your insurance carrier denies payment, the balance will be due in full from you in a timely fashion unless reasons for denial is due to an error on behalf of CC's Physical Therapy, LLC.

If you owe at least $1,000 of your insurance plan's deductible (when applicable), a mandatory payment of $85 will be due on your first visit with a mandatory minimum payment of $50 due on each subsequent visit.

If you need a payment plan set up to pay for services rendered at CC's Physical Therapy based on benefit information verified by CC's Physical Therapy, a written agreement must be signed between the patient and CCs Physical Therapy at the time of the first visit.

If any payment from your insurance carrier is made directly to you for services billed by us, you recognize an obligation to promptly submit payment to CC's Physical Therapy.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. CCs Physical Therapy will appeal Worker's Compensation denials one time in an attempt to reverse the decision. In the event an appeal is denied, it is the full responsibility of the patient to remit payment.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Interest to be applied to all outstanding balances not actively being paid on as made in agreement between the patient and CC's Physical Therapy at an annual rate of 18%.

Medicare Beneficiary

Iontophoresis is a modality that your therapist may recommend within your course of treatment. Under the rules of Medicare, this is a non-covered service. You will be billed for the administration of this modality at a rate of $50 per treatment. You have the option to decline this modality if you are not willing to pay for this cost. Your physical therapist can give you further information on the risks and benefits associated with this modality at the time of evaluation.

_____ _____

Print Name Date

_____

Patient Signature