CC's Physical Therapy

PATIENT INFORMATION

Name:_____ Birthdate: _____ Age:_____

Address: _____
Street *City* *State* *Zip code*

Male _____ Female _____ Single ____ Married ____ Separated ____ Divorced ____Widowed_____

Occupation: _____ Employed by: _____

Primary Phone: (____)_____ (CELL or HOME) Email: _____

Appointment Reminder Message Type (Please circle preferred): CALL TEXT No Reminder

Emergency Contact:_____ _____ (____)_____
Name *Relationship to patient* *Contact Number*

How did you hear about us? _____ Name of person: _____

Current Medications/Dosage/Frequency/Method of Administration: _____

_____

Please check &/or describe any of the conditions below that apply to your past & current medical history:

- ☐ Diabetes
  - ☐ Type I
  - ☐ Type 2
- ☐ Depression/Anxiety
  - ☐ Current
  - ☐ History
- ☐ Cancer
  - ☐ Active
  - ☐ Remission
- ☐ Implanted Medical Device
  - ☐ Pacemaker
  - ☐ Defibrillator
  - ☐ Pain stimulator
- ☐ Breast Implants
  - ☐ Current
  - ☐ Previously
- ☐ Infectious Disease
  (transmitted through blood or bodily fluids)
  - ☐ Hep A
  - ☐ Hep B
  - ☐ Hep C
  - ☐ HIV
  - ☐ Other
- ☐ Blood Thinner/ Anticoagulant
  Type: _____
  Last known INR:_____
- ☐ Body Piercings
  (other than on head, nose, ears, tongue)
  Location: _____

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 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.

Patient Printed Name:_____ Date: _____

Patient Signature (Guardian if < 18):_____

CC's Physical Therapy

BODY CHART:

Please list what body part/parts prompted your appointment today:

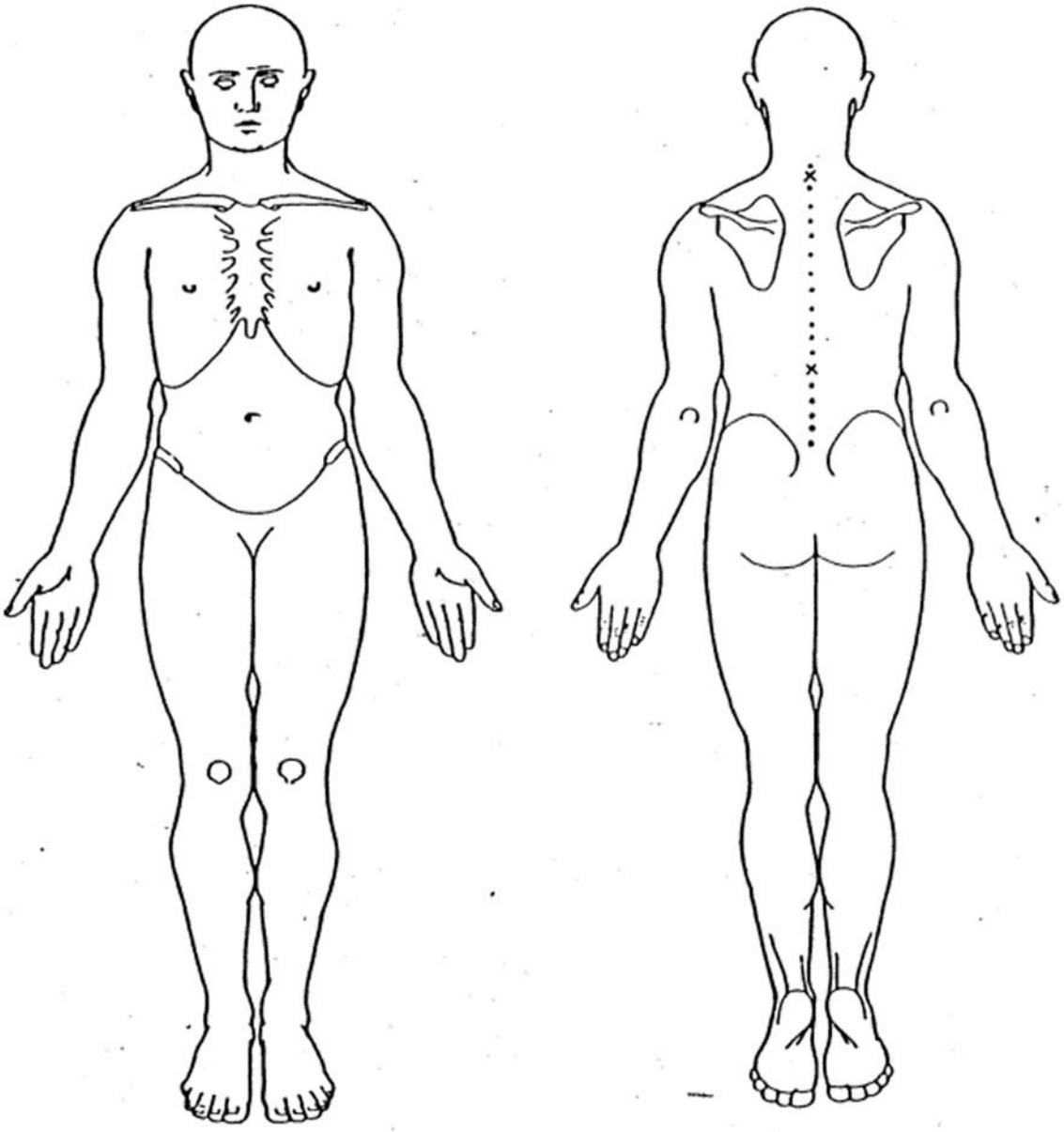
_____

Next, please indicate those same areas on the body chart below.

If more than one body part, which is your **chief complaint** today? _____

*Please put an arrow pointing to your **chief complaint** today on the body chart below.*

When did your current symptoms begin? _____



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 (Guardian if < 18) Date

CC's Physical Therapy

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. Additionally, notify your therapist if you have any piercings prior 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.

_____ _____

Patient Signature (Guardian if < 18) Date

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

Premises Conduct Consent:

CC's is a tobacco-free facility. We ask that you refrain from the use of all tobacco products while present.
We have the right to refuse service if you choose not to comply. Initial:_____

At CC's we exercise a zero-tolerance policy towards illicit drugs and alcohol use while present.
We have the right to refuse service if you choose not to comply. Initial:_____

CC's Physical Therapy

Notice of Patient Information Practices

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 Mettler. 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 purposes 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 (Guardian if < 18) 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 reason for denial is due to an error on behalf of CC's Physical Therapy, LLC.
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.

High Deductible Plans
According to benefit verification, you owe _____ of your _____ deductible. Therefore, you will be responsible for 100% of medical costs billed by CC's Physical Therapy until the full deductible amount is met. Down Payment plans are suggested at the rate of $85 for your initial evaluation and $50 for each follow up visit. This down payment will most likely not cover the entire cost of your treatment, and any remaining balance after the down payment is made will be billed out each month. If you choose to forgo a payment plan, payment of your ***balance in FULL will expected upon receipt of your monthly statement***. Initial:_____

If you wish to utilize our down payment plan for services rendered at CC's Physical Therapy, consistent and regular payments must be made as agreed upon with billing manager. Initial:_____

WSI
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. Initial:_____

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%.

_____ _____
Patient Signature (Guardian if < 18) Date