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PACE WEST physical therapy

**PATIENT INFORMATION** Today's Date _____

Full legal name_____ Gender M _____ F _____ Other___
First Middle Last
Permanent Mailing/Billing Address
_____City_____State_____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____Date of Birth_____

Emergency Contact_____ parent spouse friend other: _____
Phone _____ Email: _____
Name of Referring Doctor : _____ Date Last Seen: _____
EMPLOYER: _____OCCUPATION: _____

How did you hear about us Insurance Plan Internet Phone Book Friend Family
Who can we thank for referring you to us? _____

**PLEASE PRESENT YOUR HEALTH INSURANCE CARD TO THE FRONT DESK TO BE COPIED**

Is your injury **work-related**? Yes ____ No____

Is your injury related to a **motor vehicle accident**? Yes_____ No_____

Are you represented by an attorney? Name:_____ Phone:_____

Rate the intensity of your pain: **B** = at its best **W** = at its worse **A** = average
(for example, if on your best days your pain level is 2, write the letter "B" on the 2 on the scale below)

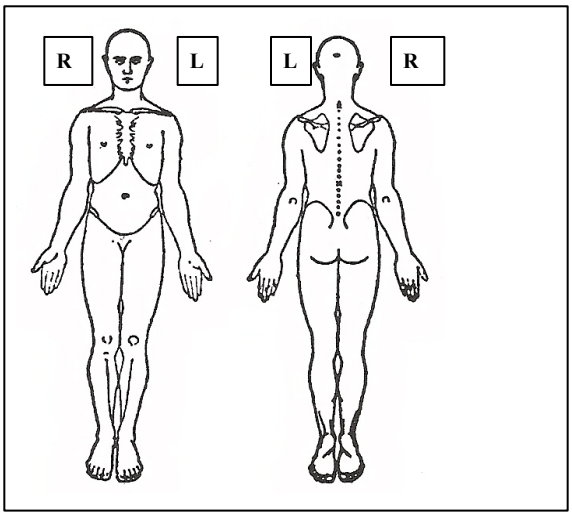
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Is your pain: Constant or does it Come and go

Is your pain getting: Better Worse Not changing

On the diagram to the right;
Please indicate where you have pain:

a. **Circle** - areas of pain
b. **XX** - areas of numbness/tingling
c. //// - areas of muscle tightness/soreness




Describe your present injury or complaint?

What goals do you have for Physical Therapy?

What position or activity eases your pain the most? _____

What position or activity aggravates your pain the most?_____

Date of injury/onset: _____/_____/_____
Date of surgery: _____/_____/_____ Name of Surgeon: _____
Type of Surgery:_____

**MEDICAL HISTORY: Check ( ✓ ) any of the conditions below that you have experienced**:

**Musculoskeletal**
Carpal tunnel syndrome
Fibromyalgia
Osteoarthritis
Rheumatoid Arthritis
Sciatica
Spinal Dysfunction
Sprains/Strains
Tendonitis
Thoracic Outlet Syndrome
TMJ Dysfunction

**Lymph and Immune**
AIDS, HIV
Chronic Fatigue Syndrome
Edema
Hodgkin's disease
Lymphoma
Lupus

**Respiratory**
Asthma
COPD
Emphysema
Tuberculosis

**Nervous**
Headaches
Multiple Sclerosis
Numbness/Tingling
Parkinson's Disease
Peripheral Neuropathy
Post Polio Syndrome
Seizures
Shingles
Stroke

**Integumentry**
Boils
Eczema
Fungal Infection
Skin Cancer
Warts

**Digestive**
Diverticulitis
Gallstones
Heartburn
Hepatitis
Irritable Bowel Syndrome
Ulcerative Colitis

**Circulatory**
Aneurysm
Clotting Disorder
Diabetes
Heart Attack
Heart Disease
High Blood Pressure
Pace Maker
Peripheral Artery Disease
Varicose Veins

**Miscellaneous**
Allergies
Cancer, other then above
Changes in Bowel Habits
Changes in Bladder Habits
Dizziness/Fainting
Fever/Chills/Night Sweats
Mental Disorder
Metal Implants
Serious Personal Injuries
Severe Night Pain
Unexplained Weight Loss

How is your general health? Poor Fair Good Excellent

What is your current stress level? Low Average High

Are you currently or have you recently taken any of the following medications? Antibiotics Anti-inflammatories Blood Thinners Heart Meds Muscle Relaxants Pain Killers Steroids

(cortisone) Other _____

Is there any chance you may be pregnant at this time? Yes No

Since the onset of this problem, have you had any of the following interventions?

Surgery MRI CT Scan X-Rays Injections Nerve Blocks Bone Scan Blood Tests Massage

Chiropractic Physical Therapy Acupuncture Other

_____

**PRIVACY PRACTICE AGREEMENTS & CONSENTS**

- I authorize the release of any medical information necessary to process the claim for services rendered.
  I further authorize payment of medical benefits directly to Pace West Physical Therapy. _____
  Patient Initials
- We stringently maintain the privacy of patient health information. A Notice of Privacy Policies is posted in the waiting room. If you wish to review our privacy practices, please ask the front desk receptionist to provide you with a copy of our policy.

- I hereby acknowledge that I consent to treatment at Pace West Physical Therapy. _____
  Patient Initials

- ***I verify that the above information is to the best of my knowledge accurate and complete.***

_____ _____
Patient or authorized person (signature) Date

Pace West Physical Therapy will to verify coverage with your insurance company in advance of your appointment. However, it is important for you to refer to your insurance policy to verify details, including limitations, regarding your coverage for outpatient physical therapy. Insurance benefits quoted are not a guarantee of payment, but only a description of your potential benefits. Final determination of benefits will be made by your insurance company upon the receipt of submitted claims.

Patients or Guarantors are responsible for paying co-pays, co-insurance, deductibles, non-covered supplies and non-covered services, services which exceed benefit limitations, and no shows and/or late cancellations. Copayments and payments for supplies and non-covered services are due at the time of service.

If you are treating as a result of an auto accident and have medical payments coverage, we will bill your auto insurance carrier directly. If your medical payments coverage is exhausted, we will subsequently bill your health insurance carrier. If you are treating as a result of a Worker's Compensation accident, your Worker's Compensation carrier will be billed directly. A referral from your MD or case manager is required.

Pace West Physical Therapy reserves the right to charge $72 for no show appointments or any cancellations not made 24 hours in advance of appointment time.

If collection and/or legal services are required to obtain payment, patient (or parent, if patient is a minor) is responsible for all costs reasonably incurred including attorney fees, court costs, collection fees and interest at a rate of 1 ½% per month.

I have read the above payment policy, and I understand my responsibilities.

_____ _____
Patient or authorized person (signature) Date

**MINOR CONSENT**: I hereby authorize Pace West Physical Therapy to provide treatment to my **child** or ward.
Print Name: _____
Relationship:_____
Signature: _____
Date:_____

**CONSENT AND RELEASE FOR TRIGGER POINT DRY NEEDLING PROCEDURE (TDN)**

This form is a consent form and general release of medical liability for the TDN procedure. By signing this form, you are agreeing not to hold Pace West Physical Therapy or its staff liable for any complications that may arise from the usual application of this procedure. Prior to receiving TDN you will be "verbally consented." This means you will be asked if you want to proceed. If you state "yes," you will not be asked to sign this form again. This form will be kept on file. You may request a copy of this consent form for your records.

**DESCRIPTION OF PROCEDURE:** During treatment for many of our patients, we commonly use a technique referred to as **Trigger Point Dry Needling (TDN).** In many cases, TDN can be helpful in resolving sub-acute and chronic pain. TDN may be very effective for your medical condition.

TDN involves placing a tiny acupuncture needle into the muscle in order to release shortened bands of muscle and decrease trigger point activity. This can help resolve pain, release muscle tension, and promote healing. This is **not** traditional Chinese Acupuncture, but instead a medical treatment that relies on a medical diagnosis to be effective. All Physical Therapists at Pace West Physical Therapy have met the requirements for Level I and Level II TDN training and have years of experience in performing the procedure.

**RISKS OF PROCEDURE:** While complications from receiving TDN are rare in occurrence, they are real and must be considered prior to giving consent for treatment. The most serious risk associated with TDN 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. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. *Additional possible complications include possible increased pain or other symptoms.* As the needles are very small and do not have a cutting edge, the likelihood of any significant trauma from TDN is minimal.

**CHARGES FOR TRIGGER POINT DRY NEEDLING:** TDN is a procedure which requires additional equipment, expertise, and liability, and in most cases is NOT covered by health insurance. The fee for the procedure is **$25.00 per session**. This fee is in addition to your per visit copayment, coinsurance or deductible. There is no additional charge for TDN if you are not using health insurance coverage, and are paying out of pocket. If your care is covered by an auto accident or liability claim, TDN will be billed to your liability insurance carrier.

Name of Patient: _____

Signature of Patient or Guardian: _____ Date: _____

Therapist's Signature: _____ Date: _____

**Telehealth Liability Waiver**

I represent and attest that I am in good health and additionally, that I am not currently under medical care for any condition that may prevent me from receiving therapy services from Pace West Physical Therapy.

By signing below I hereby acknowledge that I consent to treatment with employees from Pace West Physical
Therapy

I expressly agree and understand that all activities associated with any therapy services that are provided to me shall be done so at my own risk. Pace West Physical Therapy, its owners, agents, and employees shall not be liable for any claims, demands, injuries', damages, actions or causes of action made by any person due to injury to any person or damage to any property resulting from my participation in the activities associated with the therapy services that are provided to me by Pace West Physical Therapy.

I hereby release, discharge and hold harmless, Pace West Physical Therapy, its owners, agents, and employees from any claims, demands, actions or causes of action made by any person due to injury to any person or damage to any property resulting from my participation in the activities associated with the therapy services that are provided to me by Pace West Physical Therapy.

_____

Client/Participant Signature Date

I am the parent or legal guardian of _____ and am registering my child/ward to participate in therapy services provided by Pace West Physical Therapy. I have reviewed this Agreement and am voluntarily signing it on behalf of my child/ward in my capacity as parent or legal guardian. By signing below, I am agreeing on behalf of my child/ward to be bound along with my child/ward by all terms and conditions of this Agreement as set forth above.

_____

Parent/Guardian Signature Date

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