TRUE CARE PHYSICAL THERAPY AND REHABILITATION, PLLC

14815 W. Bell Road. Suite 110 Surprise, AZ 85374
Phone 623-777-1870 Fax 623-777-1403

DATE ______________________

Patient Information			
Patient Name: Last:	First:		Middle Initial:
Address:	City/State/Zip:		
Date of Birth:	Gender (circle one): M F		Age:
Social Security Number:	Email Address:		
Marital Status (circle one): Single Married Other			
Preferred Contact Method (circle one): Home Work Cell			
Phone: Home:	Work:		Cell:
Student (circle one): Full-time Part Time Not Student		Referred by:	

Responsible Party
Name—Last, First:
Home Phone:
Address
Work :
Cell:
Employer Name:
Employer Address:

Insurance Information	
Name of the Insurance Company:	
Insurance Co. Phone Number:	
Insurance Co. Address:	
Insurance Co. Billing Address:	
Name of Insured:	Date of Birth:
Insured's Address:	
Insured's Phone:	
Insured's Gender (circle one): M F	Social Security Number:
ID Number:	Group Number:

Referring Physician	
Date of the last Doctor Visit:	Date of Next Doctor Visit:
Date of Onset:	

Related to Accident (circle one)**:** Y N	(circle one): Work Auto Other
Accident Date:	Insurance Co. Information:
Claim Number:	Adjuster Name/phone/ fax#
Lawsuit pending (circle one): Y N	Attorney Name:
Attorney phone:	Attorney Fax:

Emergency Contact Information
Name—Last, First:
Relationship to Patient:
Contact Number (circle one): home work cell

Patient Health History

Patient Name ____

When did the pain start? _______________________________________Patient's Age __________

How did the pain start?

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Pulling ☐ Injured at work ☐ Bending ☐ Other

What activities make the pain worse?

☐ Exercise (during) ☐ Exercise (after) ☐ Sitting ☐ Walking ☐ Bending forward ☐ Voiding
☐ Bending backward ☐ Coughing ☐ Sneezing ☐ Other __________________

What reduces the pain?

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Anti-inflammatories ☐ Pain pills
☐ Injection for pain ☐ Muscle relaxants ☐ Nothing. ☐ Other__________________________________

What medications are you taking to address your pain?_____________________________________

When did you take your last pain medication?____

How long does pain medication relieve your pain?_______________________________________

List of other medications: ____

____

*** **Please see page 4 for Pain Rating Scale*****

Please check if you have had any of the following diagnostic/medical/rehabilitative services for this injury/condition:

CT Scan	MRI	Neurologist
EMG/NCV	General Practitioner	Podiatrist
Chiropractor	Physical Therapy	Other: ___________
Emergency Room Care	Myelogram	____________________
Occupational Therapy	X-Ray	Other Diagnostic Test:
Orthopedist	Massage Therapy	____________________

Please check if you have a history of any of the following:

☐ Anemia	☐ Allergies	☐ Pins or Metal Implants	
☐ Asthma/Bronchitis/Emphysema	☐ Bowel or Bladder Problems	☐ Arthritis/Swollen Joints/Gout	
☐ Blood Clot/Emboli	☐ Dizziness or Fainting	☐ Back Injury/Surgery	
☐ Cancer or Chemo/Radiation	☐ Hernia	☐ Elbow/Hand Injury/Surgery	
☐ Diabetes	☐ Numbness or Tingling	☐ Knee Injury/Surgery	
☐ Emotional/Psychological Problems	☐ Severe or Frequent Headaches	☐ Joint Replacement	
☐ Epilepsy/Seizures	☐ Varicose Veins	☐ Leg/Ankle/Foot Injury/Surgery	
☐ Heart Attack or Heart Surgery	☐ Vision or Hearing Difficulties	☐ Neck Injury/Surgery	
☐ Heart Disease/Angina	☐ Weakness	☐ Osteoporosis	
☐ High Blood Pressure	☐ Weight Loss/Energy Loss	☐ Shoulder Injury/Surgery	
☐ Infectious Disease	☐ Pacemaker	☐ Shortness of Breath/Chest Pain	
☐ Sleeping Problems/Disorders	☐ Stroke/TIA	☐ Thyroid Trouble/Goiter	
☐ Tuberculosis	☐ Are you pregnant? Y N		

Is there any further information that you would like to share with your therapist that would address your current situation? ____

What goals would you like to achieve before discharge? ______________________________

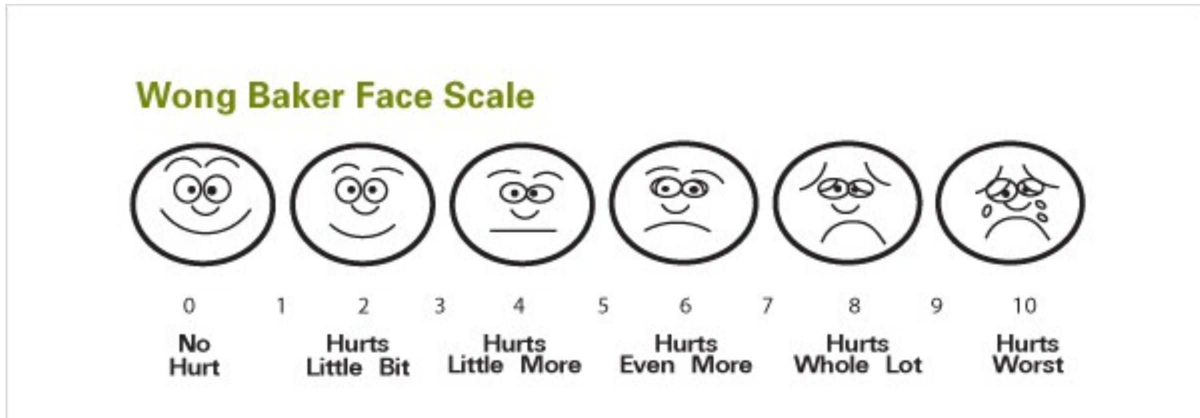
____

Patient/Guardian Signature: ______________________________**Date**_______________

I have reviewed this medical history with the patient: ______________________________

Therapist Signature

Pain Level (0-10) _____________



Pain/Symptoms

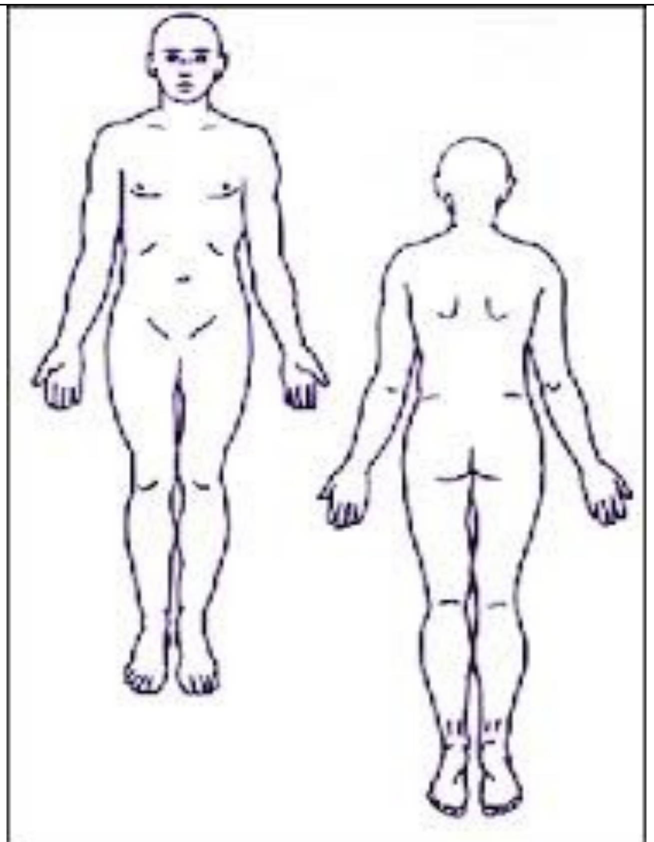
On the Body Diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp

(+) Numb/Tingling

(#) Dull/Aching

(B) Burning



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DRY NEEDLING CONSENT AND INFORMATION FORM

What is Dry Needing?

Dry needing is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), 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 the 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 patient) however; this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at 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-induce pneumothorax commonly do not occur 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, 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 needing; however, these are extremely rare events (1 in 200,000).

Is there anything your practitioner needs to know?

1. Have you ever fainted or experience a seizure? YES NO
2. Do you have a pacemaker or any other electrical implants? YES NO
3. Are you currently taking anticoagulants (blood-thinners e.g. aspirin, 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 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 wound healing? YES NO
9. Do you have hepatitis B, hepatitis C, HIV or any other infections disease? YES NO
10. Have you eaten in the last two hours? YES NO

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 at any time.

Patient's Name ______________________________Signature____________________Date____________

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FINANCIAL POLICY

True Care Physical Therapy and Rehabilitation, PLLC appreciates the confidence you have shown in choosing us to provide for your health care needs. We are committed to providing you with the best services and quality care. This guide will serve to assist in getting your services paid. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility**.** Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. You are responsible for payment of any deductible and copayment/co-insurance as determined by your contract with your insurance company, as well as any outstanding account balances. We expect these payments at the time of service. Additionally if the patient is under the age of 18 years, we consider the parent/guardian accompanying the child as the responsible party and will seek payment from that party. Sometimes, there are court orders that delineate financial obligations for medical care between a child's parents. These orders only establish responsibilities for the parents. We are not a party to this court order or bound by this court order.

*******For those patients whom are in network – We will collect $50 which would go towards your deductible. After your insurance carrier processes the date of service we will balance bill you the remainder if any.**

*******For those patients whom are not in network with the insurance we are contracted with – you will be charged $90.00 for the initial evaluation and $65.00 for each follow up visit thereafter.**

Initial ___________.

3. Non-covered services. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay in full at the time of the visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance, address, or phone number changes please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. You further understand that if you have not made payment prior to the third statement being mailed, that the statement will be marked as "final notice" and may be sent to an outside collection service if you do not fulfill your financial obligations. Added collections fees will be your responsibility. Also note that you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative Therapeutic Care. During that 30 day period, our provider will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $30 for missed appointments not canceled within 24hours of the appointment. These charges will be your responsibility and added to your balance. Multiple “no shows” will be reported to your insurance health plan and/or may result in you being discharged from our practice.

9. Checks. True Care Physical Therapy and Rehabilitation, PLLC will not accept personal or business checks. We apologize for any inconvenience this may cause you.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy of the practice and I agree to abide by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

____ _________________________
Print the name of the patient Patient date of birth

______________________ ______________________________ ______________
Print name of the responsible party Signature of patient or responsible party if a minor Date

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CONSENT FOR CARE AND TREATMENT

Physical Therapy treatment techniques may include, but are not limited to: manual techniques, spinal manipulation, electrotherapeutic modalities, and therapeutic exercises.
These may be recommended during your program. It is the policy of True Care Physical Therapy and Rehabilitation PLLC, to ensure that the benefits, side effects, and potential complications of each chosen modality above are explained to you by your therapist. Throughout the program, should you have concerns, or questions about any recommended treatment, you must inform the therapist immediately so rationale for treatment and/or adjustments can be made. It is your responsibility to participate in all aspects of the program as it is imperative to its success.
I understand and agree with the above policy. I give consent for True Care Physical Therapy and Rehabilitation PLLC, to provide me with an assessment and also treatment for services. I understand that I can withdraw my consent at any time.

I, the undersigned, do hereby agree and give my consent to True Care Physical Therapy and Rehabilitation PLLC to provide medical care and treatment to
(Patient’s Name) ____
considered necessary and proper in diagnosing or treating his/her physical condition.

________________________________ ________________
Patient Name Date of Birth

_________________________________ _________________
Patient or legally authorized signature Date

_________________________________ _________________
Print Name, if signed on behalf of patient Relationship (Parent, legal guardian, personal representative)

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Authorization to Release Medical Records

Patient Name_____________________________________ DOB___________________
Nombre del paciente Fecha de Nacimiento

This authorization releases True Care Physical Therapy and Rehabilitation, PLLC and any of its staff, employees, and agents of any responsibility for information contained in such records released in case of loss or theft from any person, or distress of any type caused by me or others. True Care Physical Therapy and Rehabilitation, PLLC will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

This Authorizes: True Care Physical Therapy and Rehabilitation, PLLC
14815 W. Bell Road. Suite 110 Surprise, AZ 85374
Phone: 623-777-1870 Fax: 623-777-1403

To Release Information to: ____
Physician's Office/ Day Care/ Parent Name)
Oficina del Medico/Guarderia /Nombre de los padres/ Guardian legal

____
(Address/ City/ State/ Zip)
Domicilio/Ciudad/Estado/Codigo Postal

____
Phone Number Fax Number (please note will not call prior to faxing)
Numero de telefono Numero de Fax

For the Following Purpose: (check one)
Por el siguente proposito: (marque uno)

____New Primary Care Physician ____Personal Records for personal use ONLY*
Nuevo Doctor Para uso personal SOLAMENTE
____Cosultation with Specialist ____ Other (Specify)____
Consulta con el especialista Otros (especifique)

Type of records requested: (check one)
Tipo de informacion requerida (marque una)

______ All Medical Records ________ The following described records only (specify types and dates)
Solo los siguentes expedients medicos (especifique tipo y fechas)

____

____**DO NOT RELEASE THESE RECORDS (specify types and dates)** ______________________________
No libere este expediente medico (especifique tipo y fechas)

____

FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS / TREATMENT INFORMATION. I understand this authorization is valid for up to 90 days unless I chose to revoke it in writing prior to the expiration date. I understand and agree that I may be responsible for ***A fee of $25.00 will be charged for records released to patient for personal use only. This charge is waived if records are forwarded to another physician's or Attorney's office.**

IF PATIENT IS 18 YRS OR OLDER, THEY MUST SIGN THIS RELEASE FORM

_____________________________________ _______________________
Signature and Name of Patient or Legal Guardian Date
Firma de los padres o Guardian legal Fecha de hoy

____
Relationship to Patient
Parentesco con el paciente

____
Office use only: Provider Approval ______________Record prepared and transmitted by:__________________Date:________________
Records released ☐ to pt in office ☐ via mail ☐ faxed to______________________________ ☐ Fee Collected

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Phone 623-777-1870 Fax 623-777-1403

Authorization to Release Medical Records
To True Care Physical Therapy and Rehabilitation, PLLC

Patient Name___________________________________ DOB__________________
Nombre del paciente Fecha de Nacimiento

This authorization releases True Care Physical Therapy and Rehabilitation, PLLC and any of its staff, employees, and agents of any responsibility for information contained in such records released in case of loss or theft from any person, or distress of any type caused by me or others. True Care Physical Therapy and Rehabilitation, PLLC will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

From: ____
Physician's Office/ Day Care/ Parent Name)
Oficina del Medico/Guarderia /Nombre de los padres/ Guardian legal

____
(Address/ City/ State/ Zip)
Domicilio/Ciudad/Estado/Codigo Postal

____
Phone Number Fax Number (please note will not call prior to faxing)
Numero de telefono Numero de Fax

To Release Information to: True Care Physical Therapy and Rehabilitation, PLLC
14815 W. Bell Road. Suite 110
Surprise, AZ 85374
Phone: 623-777-1870 Fax: 623-777-1403

Type of records requested: (check one)
Tipo de informacion autorizada (marque una)

______ All Medical Records
Todo el expediente medico

______The following described records only (specify types and dates) ______________________________
Solo los siguentes expedients medicos (especifique tipo y fechas)

____

______**DO NOT RELEASE THESE RECORDS (specify types and dates)** ______________________________
No libere este expediente medico (especifique tipo y fechas

____

This authorization shall be considered invalid after 90 days. I may revoke the authorization at any time by providing True Care Physical Therapy and Rehabilitation, PLLC written notice of revocation. However, I may not revoke the authorization retroactively for information already rendered. I hereby waive all provisions of law and privilege relating to the disclosure hereby authorized.

_______________________________________ ________________________
Signature and Name of Patient or Legal Guardian Date
Firma de los padres o Guardian legal Fecha de hoy

____
Relationship to Patient
Parentesco con el paciente **IF PATIENT IS 18 YRS OR OLDER- THEY MUST SIGN THIS RELEASE FORM**

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I hereby give my consent to True Care Physical Therapy and Rehabilitation, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).
I have the right to review the Notice of Privacy Practices prior to signing this consent True Care Physical Therapy and Rehabilitation, PLLC reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practice may be obtained by writing a request to: True Care Physical Therapy and Rehabilitation, PLLC 14815 W. Bell Rd. Suite 110, Surprise, AZ 85374.
With this consent, True Care Physical Therapy and Rehabilitation, PLLC may call my home or other alternative locations and leave message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments reminders, insurance items, and any calls pertaining to my clinical care.

I acknowledge that I have received a copy of True Care Physical Therapy and Rehabilitation, PLLC “Notice of Privacy Practices” I understand that this policy is also posted in the office for reference:

______________________________ ______________
Patient Name Date of Birth

______________________________ ______________
Patient or Legally authorized signature Date

______________________________ ______________
Print Name if signed on behalf of patient Relationship (Parent, legal Guardian, personal representative)