

**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 \_\_\_\_\_

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

<b>Responsible Party</b>
Last, First Name:
Home Phone:
Address
Work :
Cell:
Employer Name:
Employer Address:

<b>Insurance Information</b>	
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:	
Sex: (circle one) (M) (F)	Social Security Number:
ID Number:	Group Number:

<b>Referring Physician</b>	
Date of the last Doctor Visit:	Date of the Next Doctor Visit:
Date of Onset:	

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

<b>Emergency Information</b>
Last, First Name:
Relationship to Patient:
Contact Number: (circle one) home /work / cell

# TRUE CARE PHYSICAL THERAPY AND REHABILITATION, PLLC

## 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    Bending backwards    Coughing    Sneezing    Voiding    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 was your last pain medication taken? \_\_\_\_\_

How long does pain medication relieve your pain? \_\_\_\_\_

List of other medications: \_\_\_\_\_

\*\*\* Please see page 3 for Pain Rating Scale\*\*\*

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> CT Scan                      | <input type="checkbox"/> Chiropractor         | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> EMG/NCV                      | <input type="checkbox"/> Emergency Room Care  | <input type="checkbox"/> Orthopedist          |
| <input type="checkbox"/> MRI                          | <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Physical Therapy     |
| <input type="checkbox"/> Myelogram                    | <input type="checkbox"/> Massage Therapy      | <input type="checkbox"/> Podiatrist           |
| <input type="checkbox"/> X-Ray                        | <input type="checkbox"/> Neurologist          | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Other Diagnostic Test: _____ |   |   |

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

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

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

# TRUE CARE PHYSICAL THERAPY AND REHABILITATION, PLLC

**Pain Level** (0-10) \_\_\_\_\_



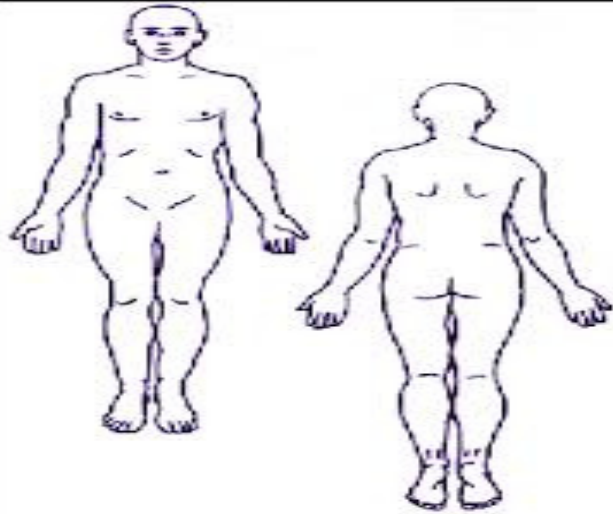
## **Pain/Symptoms**

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

- (X) Sharp
- (+) Numb/Tingling
- (#) Dull/Aching
- (B) Burning

\_\_\_\_\_

Pain Level  
(0-10)



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## DRY NEEDLING CONSENT AND INFORMATION FORM

### **What is Dry Needling?**

Dry needling 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 needling; 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 \_\_\_\_\_

# TRUE CARE PHYSICAL THERAPY AND REHABILITATION, PLLC

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623-377-1870 Fax: 623-377-1403

## 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 there after.**

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 30days 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

Numero de telefono

\_\_\_\_\_  
Fax Number (please note will not call prior to faxing)

Numero de Fax

**For the Following Purpose: (check one)**

Por el siguiente proposito: (marque uno)

\_\_\_\_ New Primary Care Physician  
Nuevo Doctor

\_\_\_\_ Personal Records for personal use ONLY\*  
Para uso personal SOLAMENTE

\_\_\_\_ Consultation with Specialist  
Consulta con el especialista

\_\_\_\_ Other (Specify) \_\_\_\_\_  
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 siguientes 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  
Firma de los padres o Guardian legal

\_\_\_\_\_  
Date  
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 siguientes 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  
Firma de los padres o Guardian legal

\_\_\_\_\_  
Date  
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)