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	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:	

Responsible Party
Last, First Name:
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:	
Sex: (circle one) (M) (F)	Social Security Number:
ID Number:	Group Number:

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

Related to Accident: 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:

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

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Patient Health History

Patient Name _____

When did the pain start? _____Patient's Age _____

Please describe how your injury occurred? _____

_____

_____

_____

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_____

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

☐Anemia	☐Allergies	☐Any 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 or Angina	☐Weakness	☐Osteoporosis
☐Weight Loss/Energy Loss	☐Shoulder Injury/Surgery	☐Infectious Disease
☐Pacemaker	☐Shortness of breath/chest pain	☐Sleeping Problems/Disorders
☐Stroke/TIA	☐Thyroid Trouble/Goiter	☐Tuberculosis
☐High Blood Pressure	☐Shoulder Injury/Surgery	

Are you pregnant? Y N

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

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

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*****

What goals would you like to achieve before discharge? _____

_____

Patient/Guardian Signature: _____Date:_____

For Therapist Use Only (Do not fill out this portion)

I have reviewed this medical history with the patient**: _____**

Therapist Signature

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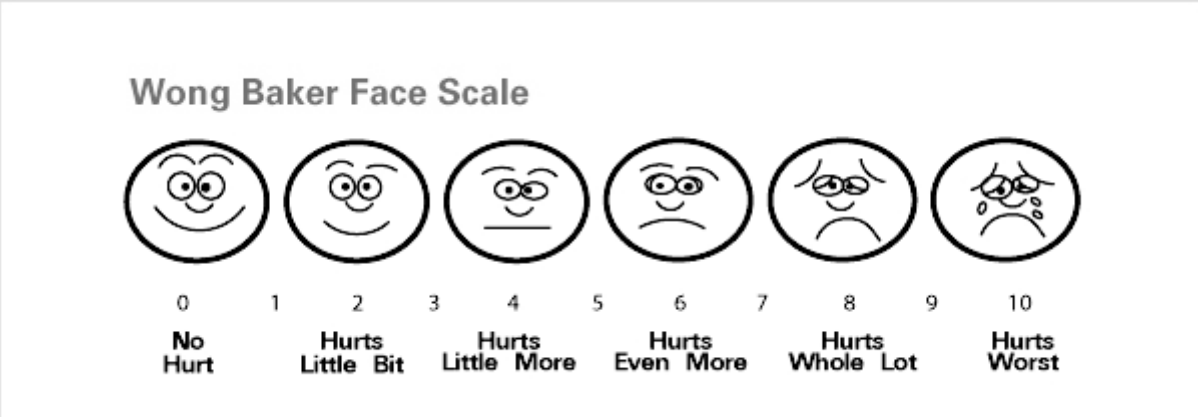
Pain Level (0-10) _____



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

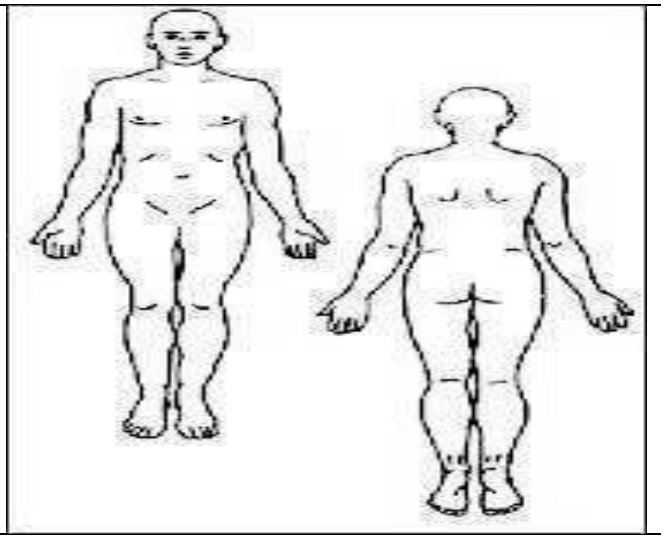
(X) Sharp

(+) 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_____

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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 $75.00 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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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)