FYZICAL®
Therapy & Balance Centers

DRY NEEDLE CONSENT

Dry needling involves inserting a tiny monofilament needle in a muscle or muscles in order to release tension in muscles and especially in trigger points. This can help resolve pain and muscle tension, and will promote healing. This is note traditional Chinese acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Dry needling is a valuable and effective treatment for pain of musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare, they are real and must be considered prior to giving consent for treatment.

PRECAUTIONS/RISKS: The most serious risk with dry needling near the thorax is puncture of the lung called pnuemo-thorax. If this were to happen, it may likely require a chest x-ray and no further treatment. The symptoms are shortness of breath and may last from days to several 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 bruise, infection and or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required and or needed, this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all item , including my questions , have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Please answer the following:

1.	Have you ever fainted or experienced a seizure?	Yes	No
2.	Do you have a pacemaker or any other electrical implants?	Yes	No
3.	Are you currently taking anticoagulants (ex blood thinners)?	Yes	No
4.	Are you currently taking antibiotics for an infection?	Yes	No
5.	Do you have a damaged heart valve, metal, or other risk of infection?	Yes	No
6.	Are you pregnant?	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, C, HIV or any other infectious disease?	Yes	No

Do not sign unless you have read and thoroughly understand this form.
You have the right to withdraw consent for this procedure at time before it is performed.

_____ _____
Patient or Authorized Representative **Date**

_____ _____
Relationship to patient (if other than patient) Patient Name (**PRINTED)**

Physical Therapist Affirmation : I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

_____ _____-
Physical Therapist **Date**

Patient Agreement of Financial Responsibility

I have been given notice in advance of treatment that my health insurer might not pay for the following non-emergent service(s): **Dry Needling 1-2 muscles**. Frederick Health expects my health insurer may not pay for this service because **it is not covered under the benefit plan**. I understand that this notice gives Frederick Health's opinion, not an official decision from my insurer.

I am scheduled to receive the above-described services from Frederick Health starting on _____, and I have been informed that I will be responsible for any and all related charges if my insurance does not cover the service. I have fully and truthfully supplied Frederick Health with all insurance coverage information.

Estimated Charges **$32.05** per daily treatment. These estimated charges are not a guarantee of actual charges. I have been notified that I am required to fully pay this estimate before receiving the service described above and am aware that this payment will be applied to my final bill. If the cost of my care exceeds the estimated charges. I will receive an additional bill.

I understand that I have the following options regarding the services described above and have indicated my selection by checking only one of the following boxes.

- ❑ **Option 1**: I want the service(s) listed above. Frederick Health may ask to be paid now, but I also want my insurer billed for an official decision on payment. I understand that if my insurer does not pay. I am responsible for payment, but I may be able to appeal to my insurer. If my insurer does not pay. Frederick Health will refund any payments I made to it, less copays and deductibles.
- ❑ **Option 2**: I want the service(s) listed above. Do not bill my insurer Frederick Health may ask to be paid now as I am responsible for payment. I cannot appeal if my insurer is not billed.

By signing this form. I understand and agree to be personally and fully responsible for the payment of the service(s) described above.

Patient name:_____ Date of Birth: ____/____/____

Patient representative name (if applicable): _____

Signature of patient or patient representative:_____

If a representative relation to patient:_____

Date: _____/_____/_____

Signature of Frederick Health representative:_____

Print Name:_____Date: ____/_____/_____

Title:_____ Department: _____