DEMOGRAPHICS/INSURANCE INFORMATION RELEASE FORM

DATE: _____

How did you hear about us? (Check one): Doctor _____ Family/Friend _____ Website _____ Advertisement ____

Patient Name: _____ **DOB**: _____ **M/F**: _____

Street Address:_____ **City/State/Zip: _____**

Home #: _____ **Cell #:**_____

Email Address: _____ **SSN#:** _____

Work Status **(circle one)**: Full Time Part-Time Self Employed Unemployed Off Work

In case of emergency contact: **Name**_____ **Phone #: _____**

Insurance Company: _____ Secondary:_____

PLEASE INITIAL ALL BELOW:

_____ ***FINANCIAL CONSENT:** If your insurance company gives our office incorrect benefits at the time of precertification, the policyholder is ultimately responsible to know his/her benefits and is therefore responsible for any portion not covered by the insurance company. Your insurance company may only provide an estimation of benefits and not a guarantee of payment.

_____ ***Payment is due** at the time of service. If we do not receive a response from your insurance company within a 90-day period, the guarantor will be responsible for the patient's balance. Reimbursement from the insurance company is the patient/guarantor responsibility. If you have no health insurance coverage, the charges that are incurred will be your responsibility. Payment is expected at the time of service.

_____ ***When you pay by check** you authorize Russell Physical therapy and fitness to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit plus tax. There is a $35 charge for returned checks.

_____ ***(IF APPLICABLE TO YOU) ACCIDENT LIABILITY/ATTORNEY:** If you are using an attorney for coverage, please provide our office with the following - attorney name, company name, claim number, phone number of pip adjuster, a signed letter of protection (both attorney and patient must sign). The patient is responsible for the deductible and any patient responsibility. We will file with your insurance if you are not covered, following this will be patient responsibility.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay any balance of said professional service charges over and above this insurance payment. Any financial debt incurred is my responsibility and not the practice. A photocopy of this assignment shall be considered as effective and valid as the original.

Signature: _____ DATE: _____

Guardian signature if patient is under 18: _____

Patient Medical History

Patient: _____ Date of Birth: _____

Referring Physician: _____

Your chief complaint: _____ Onset of symptoms/injury: _____

What are your rehabilitation goals or expectations?

Are you taking any medications that may increase your sensitivity to light?

Please Circle any of the following Medical or Rehabilitative services due to this Injury/Episode:

PHYSICAL THERAPY	Y	N	EMERGENCY ROOM	Y	N	OCCUPATIONAL THERAPY	Y	N
MRI	Y	N	NEUROLOGIST	Y	N	MYELOGRAM	Y	N
CT scan	Y	N	ORTHOPEDIST	Y	N	PRIMARY CARE	Y	N
EMG	Y	N	X-RAY	Y	N			

CONSTITUTIONAL		
GOOD GENERAL HEALTH	Y	N
WEIGHT CHANGE	Y	N
FATIGUE	Y	N
NIGHT SWEATS	Y	N
CARDIOVASCULAR		
CHSET PAIN	Y	N
CORONARY ARTERY DISEASE	Y	N
HEART SURGERY	Y	N
PACEMAKER	Y	N
MUSCULOSKELETAL		
MUSCLE PAIN/CRAMPS	Y	N
STIFFNESS/SWELLING IN JOINT	Y	N
JOINT PAIN	Y	N
OSTEOPOROSIS	Y	N
EDOCRINE	Y	N
EXCESSIVE THIRST/URINATION	Y	N
THYROID DISEASE	Y	N
HORMONE PROBLEMS	Y	N
EAR NOSE THROAT		
HEARING LOSS	Y	N
SINUS PROBLEMS	Y	N
NOSE BLEEDS	Y	N
SORE THROAT	Y	N
VOICE CHANGES	Y	N

RESPIRATORY					
SHORTNESS OF BREATH	Y	N	CHANGES IN HAIR/NAILS	Y	N
EXCESSIVE COUGHING	Y	N	RASHES OR ITCHING	Y	N
ASTHMA	Y	N	BREAST PAIN	Y	N
BRONCHITTIS	Y	N	CHANGES IN MENSTRUAL CYCLE	Y	N
EMPHYSEMA	Y	N	TUBERCULOSIS	Y	N
NEURLOGICAL					
FREQUENT HEADAHCES	Y	N	CANCER	Y	N
SEIZURES/EPILEPSY	Y	N	CHEMOTHERAPY	Y	N
NUMBNESS/TINGLING	Y	N	RADIATION	Y	N
DIZZINESS	Y	N	HIV/AIDS	Y	N
WEAKNESS	Y	N	DIABETES	Y	N
STROKE/TIA	Y	N	BLOOD CLOTS	Y	N
HEMATOLOGIC/LYMPHATIC					
BRUISE EASILY	Y	N	DEPRESSION	Y	N
SLOW TO HEAL	Y	N	INSOMNIA	Y	N
ENLARGED GLANDS	Y	N	CONFUSION	Y	N
EYES					
WEAR GLASSES/CONTACTS	Y	N	MEMORY LOSS	Y	N
BLURRED VISION	Y	N	DO YOU SMOKE?	Y	N
EYE DISEASE/INJURY	Y	N	DO YOU USE TOBACCO PRODUCTS?	Y	N
GLUACOMA	Y	N	ARE YOU PREGNANT?	Y	N
GASTROINTESTINAL					
NAUSEA/VOMITING	Y	N			
ABNOMINAL PAIN	Y	N			
KIDNEY STONES	Y	N			

SIGNATURE: _____

Patient Acknowledgement Form

Please Read and Initial:

_____ I consent to **evaluation and treatment** by Russell Physical Therapy and Fitness and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ The filing of insurance claims is a courtesy that we extend to our patients. **You will be responsible for any charges not reimbursed or contractually adjusted by your insurance company.** Should your claims not process as you expected or should you have any questions regarding your insurance plan benefits, please contact your insurance company directly.

_____ I authorize the **release of information** acquired in the course of my treatment including but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, attorney, referring physician, other third-party payers and/or the following: _____

_____ I authorize **phone, e-mail, and/or text messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ I **consent** to the treatment given to me under the general and special instructions of the attending physician. No guarantee of any results of the procedures has been given to me. I agree and give my consent to Russell Physical Therapy and Fitness to furnish medical care considered necessary and proper in diagnosing or treating his/her physical or mental condition.

_____ I understand I will be charged a **fee of $70.00 for cancelled or missed appointments without 24 hour notice**. Payment must be rendered prior to next scheduled visit.

NOTICE OF INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Fyzical Therapy and Balance Center d.b.a. Russell Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. Your personal health information may be disclosed without prior authorization when pertaining to public health purposes, auditing purposes, emergencies and when required by law. In any other situation, it is our policy to obtain your written authorization before disclosing your personal health information which you may revoke at any time.

Russell Physical Therapy may change its policy at any time, you may request an updated copy of our Notice of Information Practices at any time. You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records.

If you are concerned that Russell Physical Therapy may have violated your privacy rights or if you disagree with any decisions made regarding access or disclosure of your personal health information, please contact our office immediately. I have read and fully understand this notice of information practices. I hereby consent to use and disclose my personal health information for purpose as notice in Russell Physical Therapy Notice of Information Practices.

Please sign and date below, let the office staff know if you would like a copy for your records

_____ _____ _____

PATIENT NAME **SIGNATURE** **DATE**

BIOMEDICAL DRY NEEDLING & LASER TREATMENT CONSENT FORM

Biomedical Dry Needing involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms over time. Biomedical Dry Needling is a valuable treatment for musculoskeletal pain. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Risks of the procedure: Though unlikely, there are risks associated with this treatment. The most serious risk associated with Biomedical Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may only require a chest x-ray and no further treatment. The symptoms of pain or shortness of breath may last for several days to weeks. *A* more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication. If you feel any shortness of breath or chest pressure or pain, immediately contact your practitioner. If you suspect puncture of a lung, you should seek medical attention from your physician or go to an emergency room.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you are taking any blood thinner (such as Coumadin, Plavix or others) or if you have any conditions that can be transferred by blood. The needles are very small and do not have a cutting edge so the likelihood of any significant tissue trauma from Biomedical Dry Needling is unlikely. Other side effects or risks may include temporary swelling, soreness and minor bleeding at the site of needle insertion, muscle spasm, dizziness, fainting, tingling, drowsiness and a temporary increase in symptoms. Please consult with your practitioner if you have any questions regarding the treatment described abo*v*e.

Laser Therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. As laser therapy utilizes visible and invisible laser radiation, appropriate eye protection will be provided to you and required to wear during the entire laser session.

The amount of laser sessions needed is dependent upon the severity of your condition. You may see immediate results after the first treatment. You may feel increased soreness after your first session which is normal.

I consent to treatment by Russell Physical Therapy and Fitness and realize that I have the right to refuse any procedure. I authorized the release of information acquired in the course of my treatment including but not limited to medical records, electronic media, oral communications, to my insurance company representatives, employer, referring physician and other third-party payers.

Do you have any known disease or infection that can be transmitted through bodily fluids? YES ___ NO ___

If you marked YES to the question above, please discuss with your practitioner before any treatment.

I have read this consent, understand the risks and agree to Biomedical Dry Needling treatment and Deep Tissue Laser Therapy. If you are unsure of this treatment, you may speak with physical therapist before signing.

Signature: _____

APPOINTMENT CANCELLATIONS AND NO-SHOWS

We have set time aside specifically for you. Should you need to reschedule for any reason, please do so 24 hours in advance**.** We do understand emergencies occur, if so please let the office know as soon as possible.

If you do not arrive for your appointment or cancel less than 24-hours before your appointment, you will be charged $70.00 for the appointment.

By signing below, you are acknowledging that you have read, and understood, the above practice policy.

Name
(please print)

_____

Signature

_____

Date

_____

PLEASE PROVIDE COPIES OF YOUR INSURANCE CARDS AND A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING