Date: _____

Patient Name (First/Middle/Last):_____

Date of Birth (DOB):_____ Plan Holder DOB: _____

Phone #:_____

Home/Billing Address:_____

City/ZipCode_____

Email:_____

Physician_____

CONSENT FOR CARE AND TREATMENT:

I hereby give my consent to Therazona LLC to furnish the appropriate and necessary medical care needed to diagnose and treat the physical and mental condition of the above-named patient.

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize Therazona Physical Therapy to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Therazona Physical Therapy from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between Therazona Physical Therapy and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Workers Compensation. However, be advised if you claim Workers Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize Therazona Physical Therapy, to release all information necessary, including medical records, to secure payment.

PAYMENT FOR SERVICES & CANCELLATION/NO-SHOW POLICY:

Payments can be processed with credit cards on file? Yes ____ No____?

We understand that situations arise in which you must cancel your appointment. In such situations, we respectfully request that you provide 24 hours' notice to us (voicemails, emails accepted). This will allow us enough time to fill your appointment slot with another patient.

When cancellations are received with less than 24 hours' notice, significantly limits our ability to make the appointment available for another patient in need. Your time is valuable and ours is too.

Please note there will be a $50 fee charged to your credit card on file or billed for any appointment canceled with less than 24 hours' notice and for all No-Show appointments.

Patient or Guardian/Responsible Party Signature *(If patient is under 18 year old)*:

X_____ Date: _____

Patient Name:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the Therazona Physical Therapy Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Therazona Physical Therapy to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and Therazona Physical Therapy will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are individuals who Therazona Physical Therapy may speak to regarding my treatment. Please list names.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us? YES NO

Emergency Contact:

Name: _____ Relationship to you?_____

Contact #_____ Home, Mobile, Work#?

SIGNATURE FOR CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent For Use and Disclosure of Health Information.

Patient (Age 18 or older) or Parent/Guardian

Signature:_____Date: _____

Print Name:_____

PERSONAL/MEDICAL HISTORY

Please provide your detailed Medical History by filling out this form. Medicare requires that we keep a detailed record of your health history.

Please check ✔ Yes or No

	Y	N
Are you Pregnant?.....	☐	☐
Alzheimer's……..	☐	☐
Cardiovascular Disease……	☐	☐
Cauda Equina Syndrome……..	☐	☐
Cerebral Vascular Accident……..	☐	☐
Current Infection……..	☐	☐
Diabetes…….....	☐	☐
Fibromyalgia……	☐	☐
Fracture…….	☐	☐
High Blood pressure…….	☐	☐
Cancer (history of cancer).....	☐	☐

	Y	N
Huntington's……..	☐	☐
Immunosuppression……..	☐	☐
Lupus…….....	☐	☐
Muscular Dystrophy…….	☐	☐
Obesity……..	☐	☐
Osteoarthritis…….	☐	☐
Parkinson's…….....	☐	☐
Rheumatoid Arthritis…….	☐	☐
Pacemakers?.....	☐	☐
Other? (enter description below)...	☐	☐

_____

- Please list all surgeries, invasive medical procedures, fractures, and other serious injuries. Include approximate date and any lasting complications or disabilities:

_____

_____

_____

_____

_____

- Please list present medications that you are taking, including the dosage and frequency:

_____

_____

_____

- Reason for visit/Primary Concern?

_____

  - When did the pain/discomfort start? *(Date of injury/onset/change of status)*

    _____

    _____

- Goals of treatments?

_____

_____

Patient Name:_____

DRY NEEDLING® CONSENT AND REQUEST FOR PROCEDURE

Dry Needling® involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension and will promote healing. This is not traditional Chinese Acupuncture but is instead a medical treatment that relies on a medical diagnosis to be effective. Your physical therapist has met requirements for **Level 1** ***(25 hours of training)*** competency in Dry Needling. All training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to 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 a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's 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/needed; thus 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 items, 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 questions:

Are you pregnant? Yes No **Are you immunocompromised?** Yes No

Are you taking blood thinners? Yes No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM. *The provider will answer questions & discuss the process before the procedure.*

You have the right to withdraw consent for this procedure at any time before it is performed.

Patient or Authorized Representative

Signature:_____Date: _____

Print Name:_____

Patient Name:_____