Dany's Physical Therapy
New Patient Paperwork

Patient Information

First Name: MI: Last Name: Sex: M F

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

***Email** SSN#: Date of Birth:

***By providing my email address I understand and agree to allow Dany's Physical Therapy and it's employees to contact me via unencrypted email.**

Referring Physician: Primary Care Physician:

Employer Name: Occupation:

Primary Insurance or Motor Vehicle Subscriber Information

First Name: MI: Last Name: Sex: M F DOB:

Address: City: State: Zip:

Insurance Carrier: Member ID: Group No:

Relationship to Patient: Employer: ***SSN:**

***REQUIRED for military personnel**

Insurance Adjuster: Claim#: Policy#:

Secondary Insurance Subscriber Information (if applicable)

First Name: MI: Last Name: Sex: M F DOB:

Address: City: State: Zip:

Insurance Carrier: Member ID: Group No:

Responsible Party (if patient is minor)

First Name: MI: Last Name: Sex:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

SSN: Date of Birth: Email:

Emergency Contact

First Name: Last Name: Telephone Number:

Communication Consent

☐ **Option A**: I give Dany's Physical Therapy permission to leave detailed phone messages regarding my medical and/or billing information on:

Home# _____ ☐ Medical ☐ Billing

Cell# _____ ☐ Medical ☐ Billing

Work# _____ ☐ Medical ☐ Billing

I also authorize Dany's Physical Therapy to release ☐medical and/or ☐billing information to: _____

☐ **Option B**: I wish to be contacted personally and do not authorize Dany's Physical Therapy to leave detailed messages or discuss my care or billing account with anyone other than myself.

OFFICE USE- RTNP VERIFICATION:	
Initials	Date

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Patient Name:_____

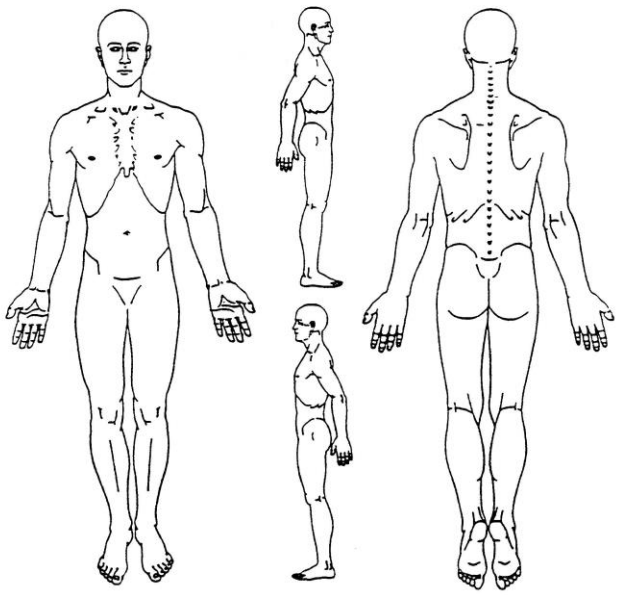
SYMPTOM DETAILS

Diagnosis (if you know or have been told)_____

_____

_____

Body part effected? (please indicate below)



Shoulder Elbow Wrist Neck Mid-back Low-back

Hip Knee Ankle Other:_____

Which side(s)? ☐ Right ☐ Left ☐ Both

Dominant arm? ☐ Right ☐ Left

Problem(s) (please check all that apply)

☐ Pain

☐ Weakness

☐ Instability/Giving way/Dislocation

☐ Stiffness

☐ Swelling

☐*Other*_____

How severe is your pain? (0=none & 10=severe)

Currently?	0	1	2	3	4	5	6	7	8	9	10
At rest?	0	1	2	3	4	5	6	7	8	9	10
When active?	0	1	2	3	4	5	6	7	8	9	10
At it's worst?	0	1	2	3	4	5	6	7	8	9	10
At it's best?	0	1	2	3	4	5	6	7	8	9	10

Do you have pain at night? ☐YES ☐NO

Does the pain awaken you from sleep? ☐YES ☐NO

Have you <u>ever</u> been seen <u>for this issue</u> by any other provider (ie. chiropractor, physician)? ☐YES ☐NO

Within <u>this year</u> have you received any of the following treatments:

☐ Physical Therapy _____# visits

☐ Occupational Therapy _____# visits

☐ Chiropractic _____# visits

☐ Home Health _____# visits

☐ None

Have you received any injections? ☐YES ☐NO

Are you post surgical? ☐YES ☐NO

Date of Surgery:_____

Type of Surgery:_____

List any additional surgeries you've received for this problem:_____

_____

Other unrelated surgeries:_____

_____

_____

This is a result of... (mark all that apply)

☐ No injury – just started hurting

Date of Onset_____

☐ Sports Injury (which sport?) _____

☐ Motor Vehicle Related (☐My Fault ☐Not at Fault)

☐ Fall Related

☐ Work/Job Related

☐ 3rd Party Accident (involving insurance other than your own)

Injury :☐Current ☐Old (greater than 1 year)

Date of Injury:_____

Please briefly describe your injury (if applicable):

_____

_____

Please tell us your goals for physical therapy:

_____

Are you currently pregnant? ☐YES ☐NO

Patient Signature **Date**

Patient Name:_____

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MEDICAL HISTORY

Please mark "yes" to any condition you currently have or have had in the past.

Arthritis	Y / N	Anemia	Y / N	Allergies	Y / N
Cancer	Y / N	Asthma	Y / N	Bladder Incontinence	Y / N
Chronic Fatigue	Y / N	Blood Clots/Phlebitis	Y / N	Concussion/TBI	Y / N
Falls	Y / N	Circulation Problems	Y / N	Depression	Y / N
Fibromyalgia	Y / N	COPD	Y / N	Eczema/Psoriasis	Y / N
Fractures	Y / N	Cystic Fibrosis	Y / N	Epilepsy/Seizure	Y / N
Headaches/Migraines	Y / N	Bronchitis	Y / N	Diabetes	Y / N
Herniated Disc	Y / N	Heart Arrhythmia	Y / N	Gallbladder Issues	Y / N
Jaw Pain/ TMJ	Y / N	Heart Attack	Y / N	Hepatitis	Y / N
Leg Cramps	Y / N	High/Low Blood Pressure	Y / N	HIV	Y / N
Lupus	Y / N	High/Low Cholesterol	Y / N	Hearing Issues	Y / N
Metal Implants	Y / N	Pacemaker	Y / N	Kidney Problems	Y / N
Osteoarthritis	Y / N	Pneumonia	Y / N	Liver	Y / N
Osteoporosis	Y / N	Shortness of Breath	Y / N	MRSA	Y / N
Polymyalgia	Y / N	Wheezing	Y / N	Multiple Sclerosis	Y / N
Rheumatoid Arthritis	Y / N	Fever/Flu	Y / N	Parkinson's Disease	Y / N
Use of Assistive Device	Y / N	Shingles	Y / N	Stroke/TIA	Y / N

PLEASE NOTE IT IS THE POLICY OF DANY'S PHYSICAL THERAPY TO NOT TREAT PATIENTS WHO ARE SYMPTOMATIC WITH CONTAGIOUS CONDITIONS OR DISEASES. IF YOU ARE CURRENTLY EXPERIENCING SYMPTOMS DUE TO CONTAGIOUS CONDITIONS OR DISEASE WE KINDLY ASK YOU RESCHEDULE YOUR APPOINTMENT UNTIL YOU ARE NO LONGER SYMPTOMATIC. IF FOUND TO BE CONTAGIOUS DURING YOUR APPOINTMENT YOU WILL BE ASKED TO RESCHEDULE AND WILL BE CHARGED A $40.00 RESCHEDULE FEE. THANK YOU.

If answered "yes" to any of the above questions, please provide details below:_____

_____

_____

CURRENT MEDICATIONS

Drug Name	Dosage	Frequency	Administration	Reason Taking

Patient Name:_____

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HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to day healthcare operations of Dany's Physical Therapy.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signed this _____day of _____, 20_____.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

Practice Name: Dany's Physical Therapy
Address: 5570 Powers Center Point
City/State/Zip: Colorado Springs, CO 80920
Phone: 719-266-6022

DRY NEEDLING CONSENT FORM

Dry Needling is a valuable adjunct treatment for chronic pain, stiffness, and to deactivate myofascial trigger points. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometime occur and must be considered prior to giving consent to the procedure.

With the dry needling technique, a fine, flexible, and sterile needle is used. The purpose of the needle is to release shortened bands of muscle caused by abnormal functioning of the nervous system. No drugs are injected.

Dry needling may cause an increase in pain for one to three days followed by an expected improvement in the overall pain state. The increased pain is related to overactive shortened muscle bands that have not been released and to the soreness caused by the "twitching" of the muscles.

Any time a needle is used there is a risk of infection. However, we are using new, disposable and sterile needles, and infections are extremely rare. A needle may be placed inadvertently in an artery of vein. If it may cause paresthesia (a prickling sensation) which is usually brief, but it may continue for a couple of days. When a needle is placed close to the chest wall, there is a rare possibility for a pneumothorax (air in the chest cavity). Fortunately, all these complications are not fatal and are readily reversible.

Patients are requested to inform practitioners about conditions such as pregnancy, pacemakers, and the use of blood thinners or immunosuppressant medications prior to treatment.

I have ready or had read to me the above; I understand the risks involved with dry needling. I have had the opportunity to ask any questions I had and all of my questions have been answered. I consent to examination and treatment at Dany's Physical Therapy including dry needling. Due to rising health care costs, non-coverage by insurance, and the costs of purchasing and disposing of needles, Dany's Physical Therapy will **charge an extra $10.00 for each session of dry needling** included with physical therapy treatments. This includes both insurance and private pay visits. We regret having to take this action, but we must seek to offset this cost. We sincerely appreciate your understanding.

Signature:_____ **Date:**_____

Patient Name:_____

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LATE AND CANCELLATION/NO SHOW POLICY

Successful rehabilitation is dependent upon you attending your scheduled and prescribed physical therapy appointments.

Late Arrivals- Patients who arrive later than 10 minutes for their appointments will be asked to reschedule their appointment regardless of the reasoning for being late. This is as a courtesy to our other patients to keep our therapists on time.

Cancellations/No Shows- We understand there will be times you will not be able to attend your appointment. In order to allow other patients the opportunity to be seen we ask you give at least 24 hours notice. Message leff within 24 hours will count as sufficient notice. If you are unable to cancel your appointment within the 24 hour time frame or just do not show up for an appointment the following fee will be applied:

- **New Evaluation/1st Appointment = $75 Fee**
- **Established Patients = $40 Fee**

Patient's that do not show (or fail to cancel within 24 hours) for *three* consecutive appointments will be discharged from care. When this occurs, your remaining appointments will be cancelled and we will notify your referring physician and/or workers compensation case manager. It is also at the discretion of Dany's Physical Therapy to discharge patients who consistently fail to keep their appointments.

Appointment Reminders- As a courtesy we will make every effort to call you and remind you of your upcoming appointment however sometimes circumstances don't allow for these calls to take place. Therefore, you are ultimately responsible for these appointments whether you receive a reminder call or not.

Please note that in the future we may switch to text message notifications to remind you of your appointments. If and when that does occur you will still be responsible for your appointments.

Signature:_____ **Date:**_____

PATIENT BILLING AGREEMENT

Consent to Treatment

I hereby authorize the following providers to deliver physical therapy treatment to me:

Dr. Dany Ridler, PT, DPT
Nicole Beldzik, PT
Dr. Anna Kallin, PT, DPT
Mary Niemeyer, MSPT
Dr. Martin Romero, PT, DPT

Filing Claims

I understand Dany's Physical Therapy files claims to my primary and secondary health insurance as a courtesy to me but any tertiary claims will need to be filed independently by me.

Contracted Insurances

I understand it is my responsibility to contact my insurance and verify they are in network with Dany's Physical Therapy. If my insurance is not in network with Dany's Physical Therapy I understand that I will have a higher out of pocket cost, and agree to pay that cost.

Authorization to Pay Benefits

I authorize payment for services provided to be made directly to Dany's Physical Therapy. If I accidently receive payment from my insurance for services received at Dany's Physical Therapy I will either sign the check over to Dany's Physical Therapy or cash the check and immediately pay the balance due regardless of if I have received an invoice from Dany's Physical Therapy or not.

Benefits

I understand it is my responsibility to know my benefits available within my health insurance plan. Dany's Physical Therapy may check my benefits as a courtesy to me but it is ultimately my responsibility to know and understand my benefits and what my insurance will and will not pay for. If my insurance has a visit limit on how many physical therapy visits they will cover I understand it is my responsibility to keep track of the number of visits used. I understand that any visits over that limit will be my financial responsibility.

Authorization/ Precertification

I understand it is my responsibility to make sure that my insurance doesn't require authorization/precertification. If authorization or precertification is required it is my responsibility to make sure it is obtained prior to being seen by Dany's Physical Therapy. If authorization is not obtained and my claim is denied I understand I will be financially responsible for the entire balance due.

Patient Name:_____

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Collecting Payment Upfront
I understand it is the policy of Dany's Physical Therapy to collect co-pays, co-insurance, and deductible amounts prior to being seen for my appointment. I understand this policy and agree to pay my respective co-pay, co-insurance, and deductible under the terms of my insurance plan.

Insurance Denials/ Unable to File to Insurance
I understand that Danys Physical Therapy files my claims as a courtesy to me and if there is any reason my claims deny (for lack of medical necessity or can't be filed due to incorrect/lack of information provided) I will be responsible for full payment of the charges. I also understand that I am responsible for resolving any disputes with my insurance over denied claims.

No Insurance
I understand that if I don't have insurance or wish to not use my insurance I will be billed at a high out of pocket rate. I also agree to pay all out of pocket costs at the time service is provided. ***Please note: Medicare patients must sign a waiver if they wish to not use their insurance.***

Supply Fees
I understand that because Dany's Physical Therapy aren't durable medical providers they can't bill certain supplies to my health insurance and therefore I am required to pay out of pocket if I wish to have certain the supplies. Some of these supplies include: *needles ($10.00), taping ($10.00), and ionto patches ($25.00).*

Statements/Collection Process
I understand that should there be a balance due on my account I will have a period of 30 days to pay any balance. After 30 days my account will become past due and will start to accrue interest in the amount of 15%. I understand that if my account becomes past due Dany's Physical Therapy will take necessary steps to collect the debt. I will be responsible for all associated fees, including collection fees, attorney fees, and court costs.

Medical Records
I understand that medical records are the property of Dany's Physical Therapy; however, I may request copies with sufficient advanced notice. There may be a charge for medical copies.

Special Forms
I understand that Dany's Physical Therapy charges a $25.00 fee for completion of special forms (such as FMLA, disability…etc.).

Signature:_____ **Date:**_____