

Dany's Physical Therapy

New Patient Paperwork



Patient Information

First Name _____ Middle _____ Last _____
Date of Birth _____ Gender _____ Appt Reminders: Call Text Email
Mailing Address _____ City _____ State _____ Zip _____
Phone (Circle Home/ Mobile) _____ Email _____

Primary Insurance or Motor Vehicle Accident Info

Insurance Carrier _____ Member ID _____ Group # _____
Referring Physician: _____ Primary Care Physician: _____
First Name _____ Middle _____ Last _____
Phone Number _____ Date of Birth _____ Gender _____
Address same as above:
Address _____ City _____ State _____ Zip _____
Relationship to Patient _____ Employer _____
Insurance Adjuster _____ Claim # _____ Policy # _____

Responsible Party (if patient is a minor)

First and Last Name _____ Date of Birth _____
Phone Number _____ Relationship to Patient: _____

Emergency Contact Details

Contact Name _____ Relationship to Patient _____
 Phone # _____ Email _____

To receive appointment reminders, check the boxes above

Communication Consent

I give Dany's Physical Therapy permission to leave detailed messages regarding my medical and/or billing information on: Phone _____ Email _____

Please provide your ID and insurance cards to the front desk.

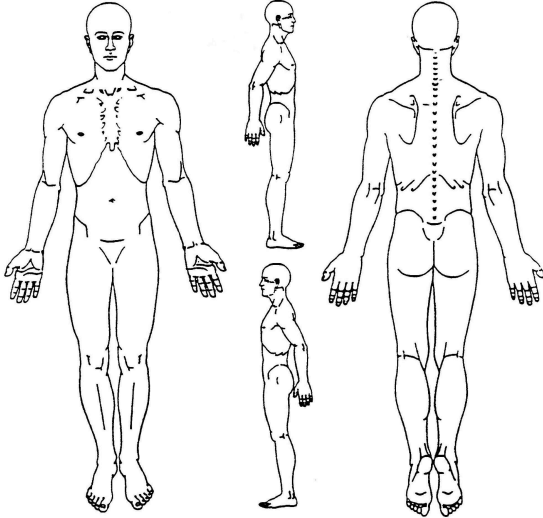


Patient Name: _____

SYMPTOM DETAILS

Diagnosis (if you know or have been told) _____

Body part affected? (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 its worst? 0 1 2 3 4 5 6 7 8 9 10
At its 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 **ever** been seen **for this issue** by any other provider (ie. chiropractor, physician)? YES NO

Since Jan 1st, have you received any of the following treatments:

- Physical Therapy _____ # visits
- Occupational Therapy _____ # visits
- Chiropractic _____ # visits
- None

Have you received any injections? YES NO

Are you post surgical? YES NO

Date of Surgery: _____

Type of Surgery: _____

Other unrelated Surgeries:

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

- No injury – 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 (more 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: _____

MEDICAL HISTORY

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

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

Please note: For the safety of our patients and staff, we do not treat individuals who are experiencing symptoms of a contagious illness. If you are currently symptomatic, please reschedule your appointment. If you arrive ill and must be rescheduled, a \$40 fee may apply. THANK YOU.

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

CURRENT MEDICATIONS

Drug Name	Dosage	Frequency	Administration	Reason Taking



Patient Name: _____

Consent Forms

Please read through the following forms carefully and in their entirety. The forms contain vital information pertaining to your treatment, charges, and insurance coverage.

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 the *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 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 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 you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the 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.

Print Patient Name _____

Practice Name: Dany's Physical Therapy
Address: 8675 Explorer Dr,
Colorado Springs, CO 80920
Phone: 719-266-6022

Responsible Party (under 18) _____ Relationship to Patient: _____

Signature: _____ **Date:** _____

LATE ARRIVAL & CANCELLATION POLICY

Late Arrivals:

Patients arriving more than **10 minutes** late may receive shortened treatment time or be asked to reschedule. If rescheduled, a cancellation fee may apply.

Cancellations / No-Shows:

A minimum of **24 hours** notice is required. Appointments cancelled with less than 24 hours' notice, or missed appointments, will incur the following fees: Initial Evaluation: \$75 or Follow-Up Visit: \$40

Fees must be paid prior to the next scheduled appointment. **Three** consecutive missed or late-cancelled visits may result in discharge from care.

Appointment reminders are provided as a courtesy; patients are responsible for keeping track of their scheduled appointments.

Signature: _____ **Date:** _____



Patient Name: _____

PATIENT BILLING AGREEMENT

Consent to Treatment

I hereby authorize Dr. Dany Ridler, PT, DPT, ART, CIDN to deliver physical therapy treatment to me.

Filing Claims

I understand Dany's Physical Therapy files claims to my primary health insurance as a courtesy but any other 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 accidentally 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.

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.

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. I understand that I will be charged the out of pocket rate for these visits.

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 Dany's Physical Therapy files my claims as a courtesy to me and if there is any reason my claims are denied (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 higher out of pocket rate. I also agree to pay all out of pocket costs at the time service is provided.



Patient Name: _____

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 supplies. Some of these supplies include:

dry needles (\$25.00), kinesio 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 advance notice. There may be a charge for printing or 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:** _____

DRY NEEDLING CONSENT FORM

Dry needling is a therapeutic procedure used to treat muscle tightness and trigger points. It involves inserting a sterile, single-use needle into muscle tissue. No medication is injected.

As with any medical procedure, risks exist.

- Common side effects: temporary soreness (24–72 hours), bruising, mild bleeding, or swelling.
- Less common risks: dizziness, fainting, nausea, nerve irritation (temporary numbness or tingling), increased pain, infection, or aggravation of symptoms.
- Rare but serious risks: excessive bleeding, injury to underlying structures, or pneumothorax (collapsed lung) when needling near the chest wall.

Sterile technique is used to minimize risk; however, no procedure is completely risk-free.

Dry needling is optional and may not be covered by insurance. A **\$25** fee applies per session.

Please inform your provider if you are pregnant; have a pacemaker or implanted device; have a bleeding disorder; take blood thinners; are immunocompromised; or have a history of fainting with needles.

I have read and understand the above information, have had the opportunity to ask questions, and consent to dry needling treatment.

Signature: _____ **Date:** _____