CITY PARK LLC
PHYSICAL THERAPY

Patient Registration

How did you hear about us? Circle all that apply: Internet Social Media Friend Advertisement Doctor

Personal Information

Last Name: _____ First:_____ MI:_____

Home Address: _____ Apt#:_____

City: _____State:_____Zip Code:_____

Date of Birth: ___/___/___ Age: ____ Marital Status: ___Married ___Single Sex: ___Male ___Female

Mailing Address (if different from above): _____

City:_____State:_____ Zip Code:_____

Wk Phone: (___)_____ Cell Phone: (___)_____ Hm Phone: (____)_____

Patient SSN (For Insurance Benefit Verification AND collections): _____ - _____ - _____

Email Address: _____

Emergency Contact: _____Relationship:_____

Emergency Contact Phone: _____

Referring Physician Name: _____

Employer Name: _____

Address: _____City:_____State:_____

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Injury / Illness:_____ Date of Injury / Onset of symptoms:_____

Is the patient wheelchair bound? Yes or No Does the patient need special accommodations? Yes or No

Primary Insurance Information

Health Insurance Company Name:_____

Subscriber's Name:_____ Subscriber DOB:_____/_____/_____

Relationship to Subscriber_____ Subscriber SSN:_____

Policy Number:_____ Group Number:_____

Secondary Insurance Information

Health Insurance Company Name:_____

Subscriber's Name:_____ Subscriber DOB:_____/_____/_____

Relationship to Subscriber_____ Subscriber SSN:_____

Policy Number:_____ Group Number:_____

Attorney or Worker's Comp Insurance Information

Is this an auto accident? □ Yes □ No Is this a work related injury? □ Yes □ No

If "Yes", list claim # and adjustor contact information below:

Claim Number:_____

Adjustor Name:_____

Adjustor Phone:_____Ext.:_____

Attorney's name:_____ Phone #:_____

Consent for Treatment

I hereby authorize CITY PARK PHYSICAL THERAPY and its employees to render therapy in accordance with my physician's orders or direct access and accepted standards of practice for physical, occupational or speech therapy. I consent to abide by the established plan of care determined by the therapist including termination of therapy services at my request, physician's request and/or the request of CITY PARK PHYSICAL THERAPY.

X

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

Assignment and Instruction for Direct Payment to Health Provider

Insurance Company/Companies Name(s):_____

I hereby instruct the above named insurance company/companies to pay by check/virtual credit card made out to and mailed directly to: ***CITY PARK PHYSICAL THERAPY*** for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy.

X

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

Patient Financial Responsibility

CITY PARK PHYSICAL THERAPY appreciates the confidence you have shown in choosing us to provide you with therapy services. The services you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Our staff will provide you with an estimate of your cost for each date of service visit. We expect these payments to be made at the time of service and recommend you leave a credit/debit/HSA card on file with our office.

In the event our staff does not collect the full amount due by you at the time of service, you will receive a statement in the mail. You are responsible for payment upon receipt of the statement or for contacting our billing company to set up an acceptable payment plan.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility.

X

Patient Signature	Printed Name	Date
X		
Parent or Guardian Signature (if under 18)	Printed Name	Date

Medical History Information

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0 = no pain, 10 = worst pain imaginable) _____

2. Do you now or have you ever had the following?

		Explanation
Stroke	yes_____no_____	_____
Heart Disease or Heart Murmur	yes_____no_____	_____
High Blood Pressure	yes_____no_____	_____
Asthma	yes_____no_____	_____
Diabetes	yes_____no_____	_____
Epilepsy/Fainting	yes_____no_____	_____
Impairment of Vision or Hearing	yes_____no_____	_____
Cancer	yes_____no_____	_____
Drug Allergies	yes_____no_____	_____
Osteoporosis	yes_____no_____	_____
Tuberculosis/HIV	yes_____no_____	_____
Arthritis	yes_____no_____	_____
Gout	yes_____no_____	_____
Emphysema/COPD	yes_____no_____	_____
Kidney Disease	yes_____no_____	_____
Bleeding Disorder	yes_____no_____	_____
Depression	yes_____no_____	_____
Dementia/Alzheimer's	yes_____no_____	_____
Other		_____

Orthopaedic History/Other – Please give dates & treatments received:

3. Have you ever sprained, strained, dislocated or fractured the following:

Neck/Head (including concussion _____
Trunk (ribs, vertebrae, sternum) _____
Low Back (vertebrae, discs, nerves) _____
Upper Extremity- shoulder, elbow, wrist, arm_____
Lower Extremity- hip, leg, knee, ankle, foot _____

4. Please list any surgeries that you have had and their dates:_____
_____
_____

5. Please list medication(s) presently taking:_____
_____
_____

6. Women: Are you pregnant or is there any chance you may be pregnant: yes_____ no_____

7. Do you smoke/dip? yes_____ no_____ If yes, how much per day?_____

8. Do you drink alcohol? yes____ no____ If yes, how much?_____

9. Do you take illicit drugs? yes____ no____ If yes, how often?_____

10. IF YOU HAVE MEDICARE OR MEDICARE ADVANTAGE COVERAGE: HAVE YOU EVER HAD HOME HEALTH CARE OR ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE (eg, is someone coming to your residence to provide any type of healthcare service to you)? yes___no___

If yes, what is the name of the agency?_____

NOTICE OF PRIVACY RIGHTS
CITY PARK PHYSICAL THERAPY

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

1. Below is a description, including at least one example, of the types of uses and disclosures that the above organization is permitted to make for each of the following purposes: treatment, payment and health care operations.

   Disclosures to other health care providers, including, for example, to patients' attending physicians. Disclosures to conduct the operations of the organization, including, for example, sharing information to supervisors of staff members who provide care to patients.

2. Below is a description of each of the other purposes for which the organization is permitted or required to use or disclose protected health information without an individual's written consent or authorization.

   To patients, incident to another permitted use or disclosure, by agreement, to the Secretary of the U.S. Department of Health and Human Services, as required by law, for public health activities, information about victims of abuse, neglect or domestic violence, health oversight activities, for judicial and administrative proceedings, for law enforcement proceedings, about decedents, for specific government functions, to business associates of the organization, to personal representatives, de-identified information, to workforce members who are victims of crimes, to workers' compensation programs, for involvement in the individual's care and for notification purposes, with the individual present, for limited uses and disclosures when the individual is not present, and for disaster relief purposes.

3. Other uses and disclosures, such as use of protected health information for marketing activities will only be made with the individual's written authorization.

4. The organization may contact the individual to schedule visits and for other coordination of care activities.

5. The individual has the right to receive confidential communications of protected health information, the right to inspect and copy protected health information, the right to amend protected health information, the right to receive an accounting of disclosures of protected health information and the right to obtain a paper copy of these privacy rights.

6. The organization is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information.

7. The organization is required to abide by the terms of this Notice currently in effect.

8. For further information, individuals should contact Vickie D. Cavitt, Compliance Officer at the following telephone number: 337.232.2444 or by email at rehabilling@yahoo.com.

Effective date: 7/23/13

PATIENT TO KEEP

Notice of Privacy Practices

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). CITY PARK PHYSICAL THERAPY has offered me a copy of their Notice of Privacy Practices for my own records.

If there is anyone you would like to authorize the disclosure of your PHI, medical or billing, you may specifically name the party below and indicate what information you would like disclosed:

1._____ Disclose:_____

2._____ Disclose:_____

X _____

Patient Signature Printed Name Date

_____

Parent or Guardian Signature (if under 18) Printed Name Date

Staff Witness Initials:_____ **Date:**_____

CITY PARK LLC
PHYSICAL THERAPY

NO SHOW/CANCELLATION POLICY

It is the policy of City Park Physical Therapy office to encourage patients to arrive and receive care at their scheduled arrival time, or to give appropriate notice of cancellation to allow other patients to receive timely care.

If you are unable to make your scheduled arrival time, we request that you notify us as soon as possible, but no later than **24 hours prior to your scheduled arrival time.** Additionally, we request that you arrive at your scheduled arrival time. In the instance where 24 hour advance notice is not provided, you **may be assessed a $25 fee for a missed office visit. In the case of a NO SHOW you will be assessed a $50 fee.**

I have read and understand this policy.

_____ _____

Patient/Guarantor Signature Date

_____

Patient/Guarantor Name Printed

If you have any questions regarding the following Dry Needling Consent form please ask your therapist at the time of your visit.

CITY PARK PHYSICAL THERAPY

DRY NEEDLING CONSENT & INFORMATION

What is Dry Needling?

Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles): tendon, ligaments or nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental medicine; that is, it does not have the purpose of alternating the ("Qi") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal problems such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, knee pain, shin splints, plantar fasciitis or low-back pain.

Is Dry Needling safe?

Drowsiness, tiredness or dizziness can occur after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15 – 20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60 – 70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the neck or head regions. Dry needling is very safe; however, serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is inducted pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-inducted pneumothorax commonly do not occur until after the treatment session and sometimes it takes several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath (SOB) on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling, however this is a very rare event and is usually temporary. Damage to internal organs has been reported in medical literature following needling; however, these are extremely rare events (1 in 200,000).

Is anything your practitioner needs to know?

Have you ever fainted or experienced a seizure? No / Yes: _____
Do you have a pacemaker or any other electrical implants? No / Yes: _____
Are you currently taking anticoagulants (blood thinners e.g. warfarin, Coumadin) No / Yes:_____
Are you currently taking antibiotics for an infection? No / Yes: _____
Do you have a damaged heart valve, metal prosthesis or other risk for infections? No / Yes: _____
Female: Are you pregnant or actively trying for a pregnancy? No / Yes: _____
Do you suffer from Metal allergies? No / Yes: _____
Are you diabetic or do you suffer from impaired wound healing? No / Yes: _____
Do you have hepatitis B, C, HIV, or any other infectious disease? No / Yes: _____
Have you eaten in the last 2 hours? No / Yes: _____

Only single-use, disposable needles are used in this clinic.

STATEMENT OF CONSENT

I confirm that I have read and understand the above information, and I consent to having dry needling treatment. I understand that I can refuse treatment and stop it at any time.

Signature: _____

Printed name: _____ Date:_____