New Core Wellness Physical Therapy PC - Patient Registration (Please Fill-Out Form Completely & Legibly)

☐ Male ☐ Female

Last Name ______ First Name ______ Age ______

Street Address ______ City ______ State ______ ZIP ______

☐ Single ☐ Married

Cellular ______ Home Phone ______ Email Address ______

Emergency Contact person ______ Phone ______ Social Security ______ Date of Birth ___/___/___

☐ **I have read and agree to all the policies disclosed on these forms.** **Signature** ______

Authorization To Release Information & Payment Request

Insurance billing:

I hereby authorize the release of any medical or other necessary information to my insurance company for claim processing. I also authorize the release of all information that my insurance company may request concerning my present and past illnesses or injuries.

Payments of Medical Benefits:

I hereby authorize payments of medical benefits to New Core Wellness Physical Therapy PC, for physical therapy services rendered to me while I was under their care. I understand that I am personally responsible for all charges associated with my treatments.

Signature ______ **Date** ______

Authorization To Receive Physical Therapy Care

I give permission to New Core Wellness Physical Therapy PC for a check-up (screening), physical therapy examination/evaluation, and for treatment. Treatment may consist of:
Modalities: Hot/Cold Packs, Cryotherapy (ice massage), Ultrasound/Phonophoresis, Diathermy, Electrical Stimulation/ Iontophoresis, Infrared, Whirlpool, Fluidotherapy, WCNE (ERT, APCT)
Manual Therapy: Joint and Soft tissue mobilization, manual stretching / traction, intramuscular stimulation (IMS), etc.
Therapeutic Exercises / Activities: Activities and exercises with and without equipment or any other appropriate treatments necessary for the patient. I have also been advised of the possible side effects of the treatment and consequences if I decide not to receive care. I understand that there is no guarantee for complete recovery.

I HAVE READ THE ABOVE PARAGRAPH AND I UNDERSTAND THE INFORMATION PROVIDED. THIS INFORMATION HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS ASKED HAVE BEEN ANSWERED TO MY SATISFACTION. I THEREFORE AUTHORIZE YELLOWSTONE PHYSICAL THERAPY PC, TO PROCEED WITH THE TREATMENT.

Signature ______ **Date** ______

General Consent For Treatment

1. **General Consent for Treatment:** I, Voluntary consent to and authorize such care and treatments, including but not limited to physical examinations, diagnostics tests and medical procedures, by employees and authorized agents of New Core Physical Therapy PC **(Clinic)** as may be considered necessary or advisable in their professional judgment. I further acknowledge that no guarantees have been made regarding the effect such treatments on any medical condition
2. **Right to Refuse Treatments:** I understand that I have the right to make informed decisions regarding all care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments I do not want.
3. I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to New **Core Wellness** Physical Therapy PC. I acknowledge that I am financially responsible for payment whether or not covered by insurances.
4. Acknowledgment of Receipt of Notice of Privacy Practices. I acknowledge that I have received the Health Notice of Privacy Practices and acknowledge that this notice is available for me to keep.

By signing below, I Acknowledge that I have read, understand and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Representative to sign this document and be bound by its terms.

Signature ______________________________ **Date** ______________________________

Acknowledgment Of Receipt Of Private Notice

By signing this form, you acknowledge that New **Core** Wel**l**ness Physical Therapy PC, has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledge receipt of this notice as soon as we can after the emergency.

Check all that are true:

☐ I have received New **Core** Wel**l**ness Physical Therapy PC Privacy Notice

☐ New **Core** Wel**l**ness Physical Therapy PC has given me the chance to discuss my concerns and questions about the privacy of my health information

Signature ______________________________ **Date** ______________________________

New **Core** Wel**l**ness Physical Therapy PC staff should complete if Acknowledgment Form is not signed

Does patient have a copy of the privacy policy ?

☐ Yes ☐ No

Primary Care Provider / Doctor Primario: ______________________________

DRY NEEDLING CONSENT AND INFORMATION FORM

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), tendons, ligaments, or near 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 altering the flow of energy (“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 conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low-back pain.

Is Dry Needling Safe?

Drowsiness, tiredness, or dizziness occurs 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%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe; however, serious side effects can occur in less than 1 per 10,000 treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath 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 you 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 even and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; these are extremely rare events (1 in 200,000).

Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. You should understand that this dry needling technique should be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment.

Is there anything your practitioner needs to know?

1. Have you ever fainted or experienced a seizure? **YES/NO**
2. Do you have a pacemaker or any other electrical implants? **YES/NO**
3. Are you currently taking anticoagulants (blood thinners e.g. warfarin, Coumadin)? **YES/NO**
4. Are you currently taking antibiotics for an infection? **YES/NO**
5. Do you have a damaged heart valve, metal prosthesis, or other risk of infection? **YES/NO**
6. Are you pregnant or actively trying for pregnancy? **YES/NO**
7. Do you suffer from metal allergies? **YES/NO**
8. Are you diabetic or do you suffer from impaired would healing? **YES/NO**
9. Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? **YES/NO**
10. Have you eaten in the last two hours? **YES/NO**

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 treatments. I understand that I can refuse treatment at any time.

Signature: ____

Printed Name: ____________________________________ Date: ________________________