CONSENT FOR TREATMENT

I consent to and authorize my physical therapist to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I understand that a physician's referral is not necessary to seek physical therapy treatment under direct access and should I choose to undergo physical therapy without a referral, I assume all risks. I acknowledge that no guarantees have been made to me about the results of treatment.

mmm

_____ _____

Signature (patient or legal guardian) Date

_____

Printed name

APPOINTMENT ATTENDANCE AGREEMENT

I understand the importance of attending therapy consistently and arriving promptly for my appointment. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment. Should I fail to provide 24hrs notice, I will be charged a late cancellation fee of $25. Should I not show up to my appointment without notice, I will be charged a no-show fee of $50. I understand that should I arrive 10 min later than my scheduled appointment time, I have the option to keep my appointment at a shortened duration at full price or cancel and be charged the $25 late cancellation fee.

_____ _____

Signature (patient or legal guardian) Date

_____

Printed name

RESPONSIBILITY FOR PAYMENT

Good Core Physical Therapy, LLC is not currently in network with any of the major insurance carriers. We are a clinic that accepts cash payment at time of service and can print a superbill for you to submit to your insurance. This is in no way a guarantee of insurance coverage/re-imbursement. In the case of late cancellation or no-show, I will be invoiced and payment must be received before scheduling my next session. I acknowledge that in consideration of the services provided to me by **Good Core Physical Therapy, LLC,** I am financially responsible for payment of my bill in full at time of service by cash, check or credit card, HSA card or FSA card.

_____ _____

Signature (patient or legal guardian) Date

_____

Printed name

EMERGENCY CONTACT INFORMATION

Person to contact in case of an emergency (who can be reached during your session):

_____

_

Name/Relationship Telephone Number

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Good Core Physical Therapy, LLC** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication for **Good Core Physical Therapy, LLC**, and with medical personnel outside of this practice as appropriate. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Good Core Physical Therapy, LLC** that provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that **Good Core Physical Therapy, LLC** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Good Core Physical Therapy, LLC** is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_____]Spouse/Children:

_____

[_____] Other:

_____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of GOOD CORE PHYSICAL THERAPY, LLC and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____

_

Signature of patient or legal representative/ Relationship to Patient

Date

_____

Printed name

EXERCISE LIABILITY WAIVER

Waiver, Release, and Assumption of Risk Form
This form is an important legal document. It explains the risks you are assuming by participation in an exercise program developed as part of my physical therapy program. It is important that you read and understand it completely. After you have done so, please print your name legibly and sign in the spaces provided at the bottom.

Waiver, Informed Consent, and Covenant Not to Sue

I,_____, have volunteered to participate in a physical therapy program under the direction of **Good Core Physical Therapy (GCPT), LLC**, which will include, but may not be limited to, weight and/or resistance training, body weight exercises, balance and stretching activities. In consideration of the agreement with GCPT to instruct, assist, and train me, I do here and forever release and discharge and hereby hold harmless GCPT, and their respective agents, heirs, assigns, contractors, and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in this or any exercise program including any injuries resulting there from. This waiver and release of liability includes, without limitation, injuries which may occur as a result of 1) equipment that may malfunction or break, 2) any slip, fall, dropping of equipment and 3) negligent instruction or supervision.

Assumption of Risk
I recognize that exercise might be difficult and strenuous and that there could be dangers inherent in exercise for some individuals. I acknowledge that the possibility of certain unusual physical changes during exercise does exist. These changes include abnormal blood pressure, fainting, disorders in heartbeat, heart attack, and, in rare instances, death.

I understand that as a result of my participation, I could suffer an injury or physical disorder that could result in my becoming partially or totally disabled and incapable of performing any gainful employment or having a normal social life.

I recognize that it is my responsibility to communicate with my therapist any reasons why I should not participate in an exercise program. I acknowledge and agree that I assume the risks associated with any and all activities and/or exercises in which I participate.

I ACKNOWLEDGE THAT I HAVE THOROUGHLY READ THIS WAIVER AND RELEASE AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. BY SIGNING THIS DOCUMENT, I AM WAIVING ANY RIGHT I OR MY SUCCESSORS MIGHT HAVE TO BRING A LEGAL ACTION OR ASSERT A CLAIM AGAINST the NSCA, or OTHERS REFERRED TO IN THIS DOCUMENT FOR ANY NEGLIGENCE OR THAT OF OUR EMPLOYEES, AGENTS, OR CONTRACTORS.

_____

Signature Date

INTAKE QUESTIONNAIRE

Name: **DOB:** **Date:**

Occupation, including activities that comprise your workday:

_____

Leisure activities, including exercise routines:

_____

Are you on a work restriction from your doctor? Yes No
Do you have a pacemaker? Yes No
Do you smoke? **Yes No**
Are you currently pregnant/think you might be pregnant? Yes No

ALLERGIES: List any allergies you are aware of (including latex):

_____

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue ❑ numbness or tingling ❑ headaches
❑ fever/chills/sweats ❑ muscle weakness ❑ difficulty swallowing
❑ nausea/vomiting ❑ dizziness/lightheadedness/fainting ❑ shortness of breath
❑ weight loss/gain ❑ heartburn/indigestion ❑ cough
❑ difficulty with balance/ # of falls ❑ changes in bowel or bladder function

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ pneumonia	❑ thyroid problems
❑ heart problems	❑ lung problems	❑ diabetes
❑ chest pain/angina	❑ tuberculosis	❑ multiple sclerosis
❑ high blood pressure	❑ asthma	❑ epilepsy/seizures
❑ circulation problems	❑ rheumatoid arthritis	❑ ulcers
❑ blood clots	❑ other arthritic condition	❑ liver problems
❑ stroke	❑ spine problem	❑ eating disorder
❑ anemia	❑ osteoporosis	❑ depression
❑ recent infection	❑ gout	❑ hepatitis
❑ eye problem/visual disturbance	❑ bladder/urinary tract infection	❑ stomach problems
❑ chemical dependency (i.e., alcoholism/drug)	❑ pelvic inflammatory disease	❑ Other:
❑ sexually transmitted disease/HIV		

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES** **NO**

Have you ever taken steroid medication (oral or injectable)? If so, when and for how long?

Please list any medications you are currently using or bring a printed list to your session (INCLUDING pills, injections, and/or skin patches):

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

Please list special tests performed for this problem (x-ray, MRI, labs, etc.)

What date (approximately) did your present symptoms start?_____
What do you think caused your symptoms?_____
What treatment have you received for this condition thus far?
_____
Have you ever had this problem before: ❑ Yes ❑ No
When_____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

INTRAMUSCULAR STIMULATION (IMS) OR TRIGGER POINT DRY NEEDLING (TDN) RELEASE FORM

The IMS/TDN treatment involves the insertion of fine filament needles into tight muscle bands or “trigger points.” These are defined as regions where the nerve meets the muscle to cause it to contract, and for some reason have not received the signal to relax. The rationale for needling these areas is to turn off the muscle. With this technique, you may feel a cramping or tightening sensation, dull ache or tingling. Your therapist will communicate to you what are normal sensations and adjust needle placement as necessary for your comfort and maximal benefit. You may feel immediate relief, or you may experience discomfort for a few days following treatment. Treatment is intended to either decrease pain, increase musculoskeletal movement, or assist in a gradual return to improved function. Again, your therapist will communicate rationale for this choice of treatment and expected outcomes.

IMS/TDN may also be used to turn on muscles that have been turned off due to disuse or deactivated due to injury. In this scenario, the needle is inserted to activate a twitch response. You may be asked to actively contract with the response to strengthen the signal between the nerve and the muscle it is to contract. Again, your therapist will communicate rationale for this choice of treatment and expected outcomes.

IMS/TDN may be used in conjunction with the application of electrical stimulation. Electrical stimulation amplifies the desired effects/response and can achieve results in a shorter duration of time than the needle alone in

some cases. Again, your therapist will communicate rationale for this choice of treatment and expected outcomes.

IMS/TDN is not to be confused with Chinese Acupuncture. IMS and acupuncture are different techniques. IMS is a scientifically proven method for diagnosing and treating both acute and chronic pain and movement dysfunction.

Like any treatment there are possible complications, though they are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

How Does It Work?

Nerves require a chemical change to activate muscle. When the chemical relationship between the two is altered by problems of the nerve (due to mechanical deformation/stretch/compression/disuse) there may be muscle pain and weakness. The immediate benefits of IMS are due to the mechanical effect of the needle. This allows “knots” to be broken up and the muscle to start working properly. The longer-term benefit comes from restoring muscular homeostasis and activation.

Contraindications:

IMS is not recommended for patients who are pregnant, have had recent surgery (12 weeks in the same region, 6 weeks in an unrelated region), have a local infection, have a systemic infection, are hemophiliacs, are on blood thinners, or are averse to this treatment modality. Please inform your therapist if you have any of the listed contra-indications or any medical cognition you think might prevent you from benefiting from this treatment modality.

Risks:

There are risks associated with IMS, as with any needling technique. There is a chance of infection. However the needles used are sterile, individually wrapped needles that are discarded after each use, and alcohol is used to prep the treatment area. A small bruise/contusion can develop where the needle is inserted if a blood vessel is hit when inserting the needle, but the needle does no permanent damage to said vessels. To avoid lung puncture

or collapse, or internal bleeding, IMS is never performed over major organs such as the lungs, or kidneys.

PLEASE CIRCLE ALL THAT APPLY AND DISCUSS WITH YOUR THERAPIST:

Recent Surgery – Pregnant – Blood Disorder – Epilepsy/Siezure - Previous Fainting – Low Pain Tolerance

Any known disease or infection that can be transmitted through bodily fluids: **YES** or **NO**
If yes, please discuss with your practitioner.

Please sign for consent of IMS/TDN treatment and that you understand the treatment and its possible risks.

_____ _____

SIGNATURE DATE

_____

PRINTED NAME

PERSONAL TRAINER/MASSAGE THERAPIST COMMUNICATION (optional, but necessary if you'd like communication performed):

_____ By initialing here I give **Good Core Physical Therapy, LLC** permission to discuss pertinent medical information related to my injury on an as needed basis with my personal trainer or massage therapist. Said communications are considered e-visits and will be billed to the patient as such.

_____ _____

Name of trainer/massage therapist Contact information (email/phone)

_____

Date