APPOINTMENT ATTENDANCE AGREEMENT

_____ I agree to provide 24hrs notice of any cancellations or rescheduling and understand that failing to do so will result in a $75 fee.

_____ I understand that if I show up later than 10 min of my scheduled appointment time I will have the option to attend my appointment with a shorter duration or cancel and incur the $75 fee.

_____ I understand that if I do not show up to a scheduled appointment without notifying GCPT in advance, I will be charged the full appointment fee.

RESPONSIBILITY OF PAYMENT

_____ I understand that **GOOD CORE PHYSICAL THERAPY, LLC** accepts cash, credit card, HSA or check as payment at time of service. I understand that if I would like to submit claims to my insurance, **GCPT, LLC** is considered an out of network provider. I agree to notify my therapist prior to starting treatment that I am requesting an invoice to submit, and I understand that this is not a guarantee of payment.

EMERGENCY CONTACT

_____ _____
Name of contact Relationship

_____
Contact's phone 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 mark the box to left):

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

_____

These restrictions to release information will remain in effect until determined in writing.

Appointment Communication Preference:[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide contact information:_____

_____ 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.

LIABILITY WAIVER

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.

3/

_____

Signature Date

NEW PATIENT QUESTIONNAIRE

Name: **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
❑ nausea/vomiting
shortness of breath
❑ weight loss/gain
❑ difficulty with balance/ # of falls ❑ changes in bowel or bladder

function

❑ muscle weakness ❑ difficulty swallowing ❑ dizziness/lightheadedness/fainting ❑

❑ heartburn/indigestion ❑ cough

PLEASE CHECK ALL THAT APPLY:

	Cancer		Thyroid dysfunction		Chest pain
	Pneumonia		Heart disease		Asthma
	Lung pathology		Diabetes		Seizures/ epilepsy
	Tuberculosis		Multiple sclerosis		High blood pressure
	Circulation problems		Ulcers		Rheumatoid Arthritis
	Blood Clots		Liver problems		Stroke
	Osteo-Perosis		Anemia		Depression
	Eating Disorder		Gout		Recent infection
	Hepatitis		Problems with your vision		Drug or alcohol abuse
	Anti-Coagulants?		Other:		

Steroid use (oral or injectable)? ___Y or ___N. If so, when: _____

Medication list: _____

_____

_____

Surgeries? Type and date: _____

_____

Please list any imaging you have had for this injury:_____

Date (approximately) your symptoms started: _____

What do you think caused your symptoms?_____

Have you ever had this problem before: ❑ Yes ❑ No

When_____**. Previous treatment?**_____

3 most Aggravating Factors: _____

Things that make your symptoms better: _____

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. Conversely, your therapist may use this technique to turn muscles which have been deactivated, back on. Your therapist may also use this technique in combination of electrical stimulation to more effectively achieve desired result.

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 longerterm 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 contraindications 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**

PERSONAL TRAINER/MASSAGE THERAPIST COMMUNICATION (optional):

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 evisits and will be billed to the patient as such.

_____ _____
Name of trainer/massage therapist email for communication

_____
Date

_____
Contact information email/phone