Patient Consent Form

Transformative Pain Care and Physical Therapy, PLLC

CONSENT TO TREAT

I consent for the physical therapists associated with Transformative Pain Care and Physical Therapy, PLLC, to provide direct evaluation and treatment to me as advised by my treating clinician. I acknowledge and consent that any claims that may arise from my treatment are only valid against the individual provider whom I am seeing on the treatment day in which the claim occurs. I hold harmless the independent providers unrelated to my care or claim.

ATTENDANCE

We ask that you please give us **at least 24 hours** in advance if you need to cancel or reschedule your physical therapy appointment. This leaves us adequate time to fill that appointment for another patient in need of care.

We seek to provide the best care on the Colorado Western Slope in a timely manner. We have a large number of patients on our waiting list and giving us a 24-hour notice allows us the opportunity to offer those patients an earlier appointment, speeding up their recovery.

We aim to provide a very personal therapy service. Please understand that this means that there are limited appointment times available for physical therapy evaluations and treatment.

There will be an **$85 charge** for unused appointments that have not been canceled 24 hours in advance and this fee will not be covered by insurance. This charge only partially covers the actual costs of an unused appointment.

If the patient has provided us a credit card to keep on file at any point throughout their treatment, completion of this form gives us advanced permission to charge this card for any late cancellation fees accrued. If a patient cancels less than 24 hours in advance or has a “no-show” 2 times for any reason, we have the right to discharge the patient so we may offer care to someone else.

We ask you to be considerate to your therapist and others needing treatment. Please give us as much notice as possible. Thank you. Please call or text **970-639-1948**, or email paindrkevin@transformativepain.com to cancel.

Thank you for your attention in this matter. We truly hope that we will never need to apply this charge. Your signature indicates that you understand and agree with the aforementioned policy.

PRIVACY

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician communications

I have been informed by you of your NOTICE of PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of practices prior to signing this consent form. I understand that this organization has the right to change its Notice of Privacy Practice from time to time, and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Act.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this content in writing at any time, except to the extent that you have taken action relying on this content.

ELECTRONIC INFORMATION

I understand that all therapists associated with Transformative Pain Care and Physical Therapy, PLLC, use a secure, HIPPA compliant, online documentation system called WebPT, as well as e-mail, fax, and cell phones (voicemail and texting) in their daily operations. I understand that technology puts some of my personal information at risk (for example, a cell phone with my contact information can be misplaced or stolen). Although therapists use password-protected devices, information regarding my treatment may be transmitted electronically, carrying with it the inherent risk of being viewed by an unintended audience. Any payment or credit card information will ONLY be transmitted on a confidential, secure payment platform (Square).

PAYMENT POLICY

Transformative Pain Care and Physical Therapy (TPCPT) accepts most major insurances. If we are non-participating providers for your insurance company, the following applies. The patient will be responsible to pay for the cost of any services provided that their insurance doesn't cover (eg Medicare does not pay for dry needling, so this will be collected at the time of service).

Transformative Pain Care and Physical Therapy is a mixed insurance and direct-pay physical therapy practice. Payment can be made via cash, check, flexible/health savings account, ATM/Debit card or credit card. Some private insurance companies may cover part or all of the services provided, with Transformative Pain Care and Physical Therapy providers considered "out-of-network" providers. It is the responsibility of the patient to obtain this information from their insurance company and submit appropriate paperwork to their insurance carrier. We can provide a detailed Superbill for services rendered. These Superbills may include diagnosis information as well as a brief description of services rendered:

- PT Evaluation
- Manual Therapy
- Neuromuscular Re-Education
- Therapeutic Exercise
- Dry Needling
- Wellness/Prevention

Note that most traditional health insurance companies ONLY cover services aimed at restoring patients to a reasonable level of function following an injury or disease. Services such as therapeutic massage, wellness/prevention, performance enhancement and maintenance therapy do not typically fit these criteria. Health Savings Accounts and Flexible Savings Accounts may be more amenable to covering such services.

"I have read and understand the Patient Agreement for Payment Policy and understand that it is my responsibility to work with my health insurance, HSA or FSA to try to obtain any reimbursement that I may be eligible for."

Consent to perform Dry Needling (DN)

Dry needling involves placing a small needle into the muscle at the trigger point (an area where the muscle is tight and may be tender) with the intent of causing the muscle to contract and then release, improving its flexibility and decreasing the symptoms.

Dry needling is a valuable treatment for musculoskeletal-related pain such as soft tissue and joint pain, and has been found to increase muscle performance. Like any treatment there are possible complications. While these complications are **RARE** in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

Risks of the procedure:

Though unlikely, there are risks associated with this treatment. The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and, in skilled hands, should not be a concern. If you feel any related symptoms, immediately contact your DN provider. If a pneumothorax is suspected, you should seek medical attention from your physician or go to the emergency room.

Other risks may include bruising, soreness, infection, and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require anticoagulants or any other conditions that may have an adverse response to needle punctures. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from DN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above, and answer the following:

Yes / No	Do you have any known disease or infection that can be transmitted through bodily fluids?
Yes / No	Are you pregnant?
Yes / No	Are you immunocompromised?
Yes / No	Are you taking blood thinners?

If you answer yes to any the above, please discuss with your practitioner.

I AGREE TO ALL OF THE ABOVE NOTED POLICIES OF TRANSFORMATIVE PAIN CARE AND PHYSICAL THERAPY

_____ _____

Patient/Parent Signature Date

TRANSFORMATIVE PAIN CARE AND PHYSICAL THERAPY, PLLC – MEDICAL HISTORY FORM

Name: _____ DOB: _____ Age: _____

Primary Complaint: _____ Date of onset: _____

Referred by: _____ Primary Physician: _____

Other clinicians you are currently seeing: _____

Date of next MD appointment: _____

Date of last MD appointment: _____

BODY CHART

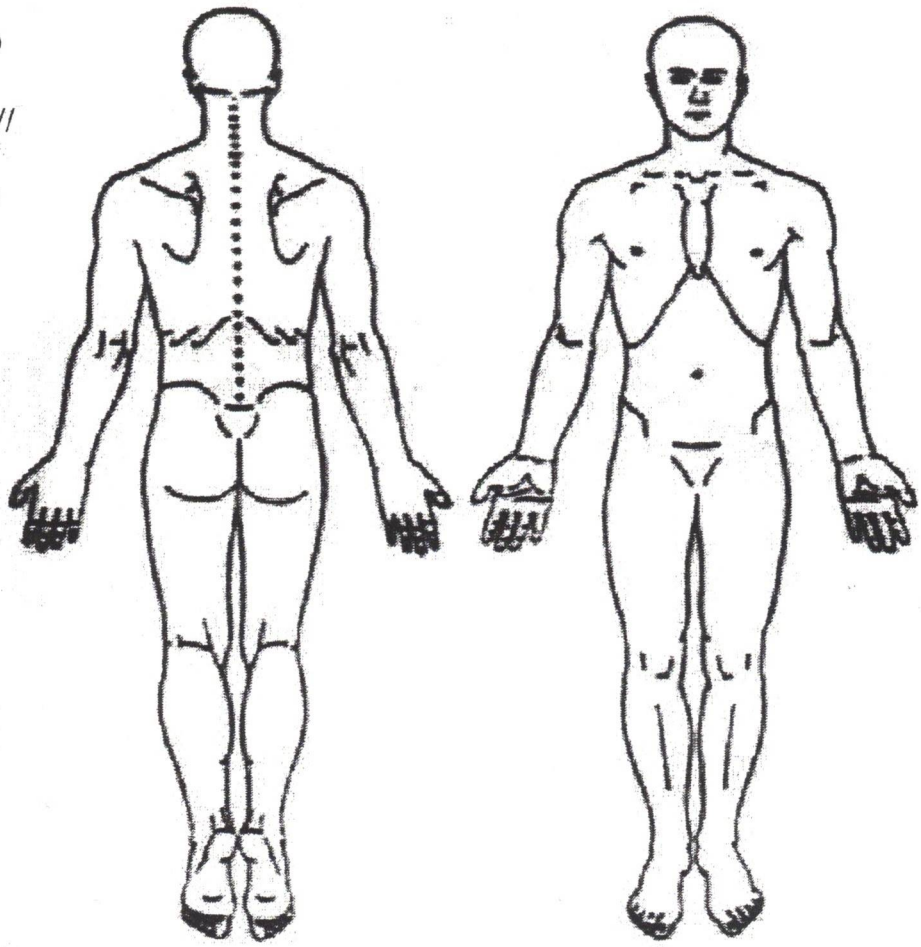
Please indicate the area(s) of concern:

Pain: XXXX

Numbness: OOOO

Tingling: ////////////

Other Sensations:



SYMPTOMS

Do you have, or have you recently had, any of the following?

□ Blood in urine, stool, vomit, or sputum	□ Cough	□ Difficulty swallowing/speaking
□ Dizziness, fainting, blackouts	□ Dribbling of urine	□ Memory loss
□ Fever, chills, sweats (day or night)	□ Inability to tolerate exertion	□ Confusion
□ Nausea, vomiting, loss of appetite	□ Numbness / tingling	□ Sudden weakness
□ Bowel/bladder (diarrhea/constipation)	□ Swelling or lumps anywhere	□ Trouble sleeping
□ Throbbing sensation	□ Problems seeing or hearing	□ Skin rash or other changes
□ Unexplained weight loss or weight gain	□ Unusual fatigue, drowsiness	□ Heart Palpitations / fluttering
□ Heat or cold intolerance	□ Joint pains or muscle cramps	□ None of these

MEDICATIONS

Please list any current prescription or over-the-counter medications, supplements, or herbal products:

_____

_____

_____

_____

_____

Are you on Coumadin (Warfarin)? □ Yes □ No

SOCIAL HISTORY

Tobacco Use: □ Yes □ No □ Previously, but I quit When did you quit?_____

If yes, # of years you've smoked/chewed ____ Amount you smoke/chew per day _____

Alcohol Use: □ Yes □ No □ Previously, but I quit When did you quit?_____

If yes, how often and how much do you drink? _____

Illicit Drug Use: □ Yes □ No □ Previously, but I quit Please specify: _____

Caffeine Intake: _____ # drinks/servings per day Nutrition Concerns? _____

Artificial sweeteners (NutraSweet, Aspartame, Splenda, etc.): □ Yes □ No __ # drinks/servings per day

Occupation: _____ Company worked for: _____

Living Situation: □ Alone □ With someone □ Home/apartment □ Other: _____

Marital Status: □ Married □ Single □ Widowed □ Divorced □ Other

OTHER

Do you have any religious or cultural concerns that may affect your treatment? □ Yes □ No

If yes, please specify: _____

Do you have any barriers to learning that your therapist should be aware of? □ Yes □ No

If yes, please specify: _____

Do you have any other symptoms, anywhere else in your body, not covered above? □ Yes □ No

Please share anything else about your health history that you would like to share not covered above:

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____