



Patient Name: _____ Patient Phone _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Rights & Responsibilities

I acknowledge the receipt of information pertaining to my right to accept or decline the disclosure of my personal health information that is protected by HIPPA policy to PT Link, LLC. In granting my permission, I will allow my personal health information to be shared with PT Link LLC, to screen for any physical or environmental needs that may or may not be present.

Consent for Treatment

I hereby give my permission for authorized personnel of PT Link, LLC to perform all necessary procedures to assess for any needs delivered via physical therapy care. If applicable, I understand my physician will be contacted and services will be rendered through PT Link. I understand that PT Link will supervise services provided, I may refuse treatment or terminate services at any time, and PT Link may terminate their services to me as explained in my orientation. I agree and consent to allow my personal health information to be shared with PT Link. In doing so, I consent to allow a professional from PT Link including but not limited to physical therapy assess my needs.

Release of information

I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that PT Link may use or disclose protected health information from insurance companies, health plans, Medicare, Medicaid, or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services, any person or entity affiliated with or representing for purposes of administration, billing, and quality and risk management; any hospital, nursing home, or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care: family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and other health care providers in order to initiate treatment.

Consent to Photograph

I hereby consent for PT Link to take pictures of myself, and treatment being done and consent to the release of those photographs for use in advertisement or public education regarding physical therapy services or to insurance providers to document my medical condition.

Advance Directives

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive (Living Will/Durable Power of Attorney for Health Care) so that my wishes may be known when I am unable to speak for myself.

1. I have made a Living Will ___No ___Yes (if yes, provide a copy to the agency.)

2. I have made a Durable Power of Attorney for Medical Care ___No ___Yes (If yes, write the name & phone number of the person given power of attorney.

I authorize PT Link, LLC to use and disclose the protected health information described above to the following individuals:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from PT Link care. I also understand that I may revoke this consent in writing at any time.

Patient's Signature

Responsible person or legal guardian's signature/person Authorized to sign

Witness Signature/Agency Representative

Printed Name & Relationship of Person Above

Patient unable to sign due to _____



Integrative Dry Needling Consent Form

Integrative Dry Needling involves placing a small needle into the tissue that is tender with the intent to normalize the physiology of the area and regain homeostasis, which will improve the function of the musculoskeletal system resulting in symptom reduction.

Integrative Dry Needling is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Risk of the procedure:

Though unlikely, there are risks associated with this treatment. The most serious risk associated with Dry Needling 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. The symptoms of 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.

Other risks may include bruising, infection, and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. 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 Dry Needling is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily fluids?

YES ___ NO ___

If you marked YES, please discuss with your practitioner.

Please Print your Name: _____

Signature: _____ Date: _____



PERSONAL MEDICAL HISTORY

Have you **EVER** had any of the following? Please check the box to the right if yes.

Heart Disease		Arthritis	
High Blood Pressure		Osteoporosis	
Diabetes		Osteopenia	
Heart Attack		Seizures	
COPD/Emphysema		Parkinson's	
Asthma		HIV/ Hepatitis	
Stroke		Pacemaker	
Cancer		Other	

Are you a current smoker: (Check one) YES ___ or NO ___

Please list all surgeries:

Please list any allergies:

Please list medications:

Signature of Patient: _____ **Date:** _____



PT Link Good Faith Agreement

I agree by my signature on this good faith agreement, that I will maintain the treatment schedule prescribed by my doctor and physical therapist. The criteria by which I may be discharged and/or may incur a fee for non-compliance are as follow:

- **Three (3) cancellations will be cause for discharge**
- **Three (3) no- shows will be cause for discharge**
- **Also, your referring doctor will be notified of your non-compliance**
- **Any exceptions to these criteria will be handled by the therapist on a case-by-case basis**

24-hour notice must be given for all physical therapy visits

- **\$25.00 for a missed office visit with a physical therapist/physical therapist assistant**

You must make payment immediately when a no-show cancellation charge has been assessed to your account in order to schedule any appointments or to avoid cancellation to other appointments previously scheduled.

Physical Therapy is very important to you, your therapist and your physicians. So, keeping all of your appointments are essential.

Patient Signature: _____ Date: _____



Patient History (Please Print)

Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____
Date of Birth _____ Social Security Number ____ - ____ - _____ Gender: Male ___ Female ___
Employer _____ Occupation _____
Referring Physician _____ Primary Care Physician _____

Source of Referral (Check One)

Physician ___ Patient ___ Family/Friend ___ Direct Access ___ Insurance ___ Internet ___ Mail ___
Other: _____

In case of an emergency, please list a relative or friend to contact:

Name _____ Home Phone _____ Cell Phone _____

Insurance

Primary Insurance Policy Holder Name _____
Primary Insurance Group Number _____
Policy Holder Social Security number ____ - ____ - _____ Date of Birth: ____ - ____ - _____
Secondary Insurance Policy Holder Name _____
Secondary Insurance Group Number _____
Secondary Policy Holder Social Security number ____ - ____ - _____ Date of Birth: ____ - ____ - _____

Is this a Worker Compensation Claim? (Check One) YES ___ or NO ___

If "Yes" Claim Number: _____

Case Worker Name: _____ Phone: _____

Insurance Carrier _____ Claim Number _____

Claim Mailing Address _____ City _____ State ___ Zip _____

Is this an Auto Accident Claim? (Check One) YES ___ or NO ___

If "Yes" Claim Number: _____

Claim Rep Name: _____ Phone: _____

Insurance Carrier _____ Claim Number _____

Claim Mailing Address _____ City _____ State ___ Zip _____