PATIENT REGISTRATION

**Today’s Date**: \_\_\_\_\_/\_­\_\_\_/\_­\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_­\_\_\_/\_­\_\_\_ Age: \_\_\_\_\_\_\_\_ Sex: □ Male □ Female Height \_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_­­­­­­­­­­­\_\_\_\_

Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cell □ Home □ Work

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ F/T □ P/T □ Retired □ Student □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact name/Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Card Holders Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are your injuries a result of a motor vehicle accident?:** □ Yes □ No **Date**: \_\_\_\_\_/\_­\_\_\_/\_­\_\_\_

**Are your injuries a result of a worker’s compensation accident**?: □ Yes □ No **Date**: \_\_\_\_\_/\_­\_\_\_/\_­\_\_\_

*If the answer to either of the above questions is yes, please provide the following information so that we may bill the appropriate company for your physical therapy services.*

Ins. Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjuster:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I give my written consent to be photographed/videotaped during my treatment for:**

□ Therapeutic Use Only □ Promotional Materials (including social media) □ I do not want to participate

Please Initial

**Whom may we thank for referring you to CT Sports Physical Therapy?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Yelp | * Google | * Facebook | * Ctsportspt.com | * Other (Please specify above) |

MEDICAL HISTORY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: □ Male □ Female

When is your next scheduled follow up appointment with your physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received X-Rays or MRIs related to your injury? □ Yes □ No

If yes, please list *date* and *results*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgeries in the past? □ Yes □ No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies we should be aware of? □ Yes □ No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have, or have you ever had any of the following:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| High or low blood pressure |  |  | Osteoporosis |  |  |
| Heart problems or cardiac irregularities |  |  | Alcohol or drug problem |  |  |
| Family history of cardiac problems |  |  | Neck strain |  |  |
| Pacemaker or metal implants |  |  | Low back pain |  |  |
| Cancer (indicate type) |  |  | Fractures |  |  |
| Family history of cancer |  |  | Arthritis (indicate joint) |  |  |
| Recent unexplained weight loss |  |  | Ligament sprain, muscle strain |  |  |
| Respiratory ailments |  |  | Diabetes (type 1 or 2) |  |  |
| Systemic disorders (i.e. RA, MS, AIDS, etc.) |  |  | Intestinal organ problems (stomach, kidneys, etc.) |  |  |
| Allergies including latex or medications |  |  | Thyroid condition |  |  |

**If you answered yes to anything above, please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medication List** *(If you have a list, we will make a copy)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Route (oral, enteral, etc.)** | **Dosage** | **Frequency** |
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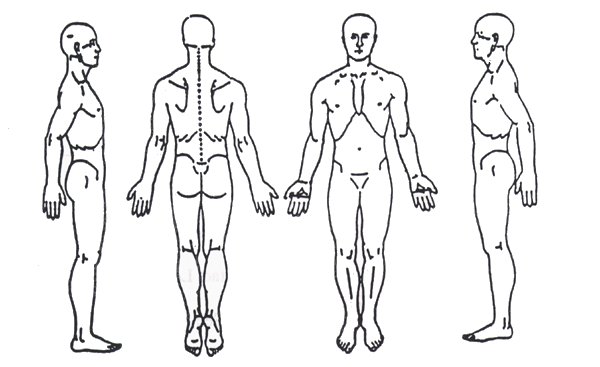
PAIN/SYMPTOMS

* Please mark your pain on an average day by making a mark on the scale below.

0 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 10

No Pain ER Visit

* On the Body Diagram below, please mark your symptoms with an X.



* Have you had physical therapy in the past year for this injury? □ Yes □ No
  + If Yes, please list date(s): \_\_\_\_ /\_­\_\_\_ /\_­\_\_\_
  + If yes and **Medicare** patient, please contact billing representative.
  + If you have received physical therapy for a separate injury in the past year, please explain below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had two or more falls in the past year? □ Yes □ No**

**Have you had a fall in the past year that resulted in injury? □ Yes □ No**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (parent or legal guardian) Date

PATIENT RESPONSIBILITIES

**Please read each of the following and initial at the end. Sign and date at the bottom.**

* It is the patient’s responsibility to know your insurance benefits and policy requirements for office visits and procedures (therapy).
* It is the patient’s responsibility to bring your current insurance card(s) and method of payment for each office visit.
* It is the patient’s responsibility to update your insurance information, current address and contact information for our records. Failure to do so will cause the patient to become responsible for all charges.
* It is the patient’s responsibility to provide a current therapy prescription and/or referral prior to treatment (if applicable).
* It is the patient’s responsibility to inform the front desk and therapist if you have been seen at another clinic for physical therapy.
* It is the patient’s responsibility to inform the front desk and the therapist if your treatment is the result of an auto accident or if you were injured at work or school.
* It is the patient’s responsibility to keep follow-up appointments as scheduled. Your therapy program requires a commitment and attending your appointments on a consistent basis is necessary for you to achieve optimal improvement. Failure to show up for appointments can result in a delay of your Plan of Care. Your attendance is critical.
* It is the patient’s responsibility to notify our office 24 hours prior to your scheduled appointment if you are unable to keep your appointment. Failure to do so will result in a $75.00 no show/cancellation fee which must be paid prior to scheduling your next appointment.
* Failure to no show 2 consecutive appointments and/or accounts no longer maintained in good faith status may result in termination of your provider-patient relationship with CT Sports Physical Therapy & Wellness.
* It is the patient’s responsibility to fully participate in decisions involving his /her own health care and to accept the consequences of those decisions.

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**Initial**

MEDICAL ASSIGNMENT OF BENEFITS & FINANCIAL POLICY

**Please read each of the following and initial at the end. Sign and date at the bottom.**

* I understand that I have medical insurance, which when billed on my behalf, will (should) pay for my office visits.
* I understand this process may take 4-8 weeks. At that time, my insurance company will determine and pay for services according to my insurance plan benefits.
* I understand it is my responsibility, and agree, to pay all copays, co-insurance, deductibles, or “cash pay” estimated amounts at the time of service.
* I understand that a copy of my explanation of benefits (EOB’s) will be sent to me by my insurance company when the claims are processed.
* I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed.
* I understand that if my account balance is not paid within 30 days from the date of my final statement, that a $50 collection fee will be added to my account and that my account may be referred to a collection agency.
* I thereby assign all medical benefits to CT Sports Physical Therapy & Wellness.
* I authorize CT Sports Physical Therapy & Wellness to release my medical information to insurance companies, physicians, attorneys and to all pertinent parties that may be involved in my claim or care.

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**Initial**

**I have read and understand my responsibilities and benefits as a patient. All my questions have been answered.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (parent or legal guardian) Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION & INFORMED CONSENT FOR PHYSICAL THERAPY CARE

I, hereby agree to a physical therapy evaluation and routine treatment by a Connecticut licensed physical therapist. I understand that the physical therapy treatment will be provided for the identification, prevention, remediation, and rehabilitation of an acute or chronic physical dysfunction. I understand that my physical therapist will have me involved in the decisions of my care always. My consent to any treatment set forth is voluntary and I may withdraw any such consent at any time and to any aspect of the prescribed treatment.

**Benefits to be expected**

Although no assurance can be given and every case is individual, common benefits associated with regular participation in a physical therapy program include, but are not limited to, improvement in joint range of motion/flexibility, muscle strength, body mechanics, decreased pain levels, and reduction in future injury risk with the primary goal to restore maximum functional independence.

**Risks and Discomforts**

As with any medical procedure or treatment there are risks. These include abnormal blood pressure, fainting, disorders of heart rhythm, excessive perspiration and, in very rare instances, heart attack, stroke or death. Every effort will be made to minimize those risks by the initial examination/evaluation and by observations during the therapy sessions. If you have any concerns or questions about a portion of the proposed treatment, please notify your physical therapist and he/she will address these issues.

**Your responsibility as a patient**

To gain the expected benefits of treatment, you must give priority to regular attendance and adherence to prescribed amounts of intensity, duration, frequency, progression and type of activity and will report any unusual symptom(s) which you may experience before, during, or after a physical therapy treatment session.

**Authorization to Release Information/Record Requests**

To make informed decisions regarding your physical therapy treatments, it is helpful for your physical therapist to have access to your medical records. By signing below, you authorize release of your medical, hospital, or surgical records to CT Sports Physical Therapy & Wellness pertinent to your physical therapy treatment, including but not limited to imaging, exams, surgical reports, special tests, or lab results. In addition, I authorize the release of my physical therapy treatment information to insurance companies or attorneys as needed to facilitate approval or payment, except for the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that by signing this authorization:**

* I authorize the use or disclosure of my individually identifiable health information.
* I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
* I have the right to copy of this authorization.
* I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
* I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medial information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (parent or legal guardian) Date

***\*\* IF YOU ARE INTERESTED IN RECEIVING DRY NEEDLING TREATMENT, PLEASE READ BELOW\*\****

DRY NEEDLING CONSENT & INFORMATION FORM

**What is Dry Needling?**

Ry 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 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, 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; however, this is not necessarily a “bad” sign. Fainting can occur in certain patients (0.3%), 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 (less than 0.01%) treatments. The most common serious side effect 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 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 your 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 event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000).

**Is there anything your practitioner needs to know?**

* Have you ever fainted or experienced a seizure? □ Yes □ No
* Do you have a pacemaker or any other electrical implant? □ Yes □ No
* Are you currently taking anticoagulants (blood-thinners e.g. aspirin, warfarin, Coumadin)? □ Yes □ No
* Are you currently taking antibiotics for an infection? □ Yes □ No
* Do you have a damaged heart valve, metal prosthesis or other risk of infection? □ Yes □ No
* Are you pregnant or actively trying for a pregnancy? □ Yes □ No
* Do you suffer from metal allergies? □ Yes □ No
* Are you a diabetic or do you suffer from impaired wound healing? □ Yes □ No
* Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? □ Yes □ No
* Have you eaten in the last two hours? □ Yes □ No

**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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (parent or legal guardian) Date