BODYWISE
PHYSICAL THERAPY

Patient History Form

Name:_____ **Date of Birth:**_____

Have you recently noticed any of the following symptoms? Check all that apply.

- ☐ Change in bowel/bladder function
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance while walking
- ☐ Changes in appetite
- ☐ Fevers/chills/sweats
- ☐ Weakness/fatigue
- ☐ Difficulty swallowing
- ☐ Weight loss/ gain
- ☐ Headaches
- ☐ Feeling depressed
- ☐ Extreme anxiety

Have you ever been diagnosed with any of the following conditions? Check all that apply.

- ☐ Cancer (type?)_____
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Asthma
- ☐ Diabetes
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Kidney/liver problems
- ☐ Pacemaker inserted
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Other_____
- ☐ Anemia
- ☐ Lung problems
- ☐ Thyroid problems
- ☐ Epilepsy
- ☐ Stomach ulcers
- ☐ Rheumatoid arthritis
- ☐ Other_____

Please list any medications you are currently taking (including any blood thinners/anticoagulants):

_____

_____

Please list any allergies: **Are you latex sensitive? YES/NO**

_____

_____

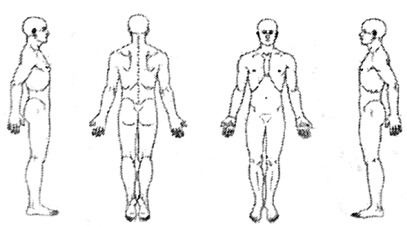
Do you smoke? YES/NO **If yes, how many packs per day?** _____ **Are you currently pregnant? YES/NO**

Please list any past surgeries or hospitalizations (including dates):

_____

What is your main complaint? _____ **When did your symptoms start?** _____
What are your symptoms? _____ **What makes it worse?** _____
What makes it better? _____ **Are there any activities you are unable to do?** _____
Have you been treated for this issue before? Where/When? _____
Describe your pain (dull, achy, sharp, constant, intermittent, only with certain movements, etc.):

_____
What are your physical therapy goals? _____
On a scale from 0 to 10, how would you rate your pain? (0 - no pain, 10 - worst pain ever) please circle: 0 1 2 3 4 5 6 7 8 9 10



Body Chart: using the key below, please mark the location of your pain and type of pain:
X sharp stabbing pain
O dull achy pain
.... numb/tingling
/// throbbing
=== burning

Patient Signature: _____ **Date:** _____

4440 Arapahoe Ave, Ste 101, Boulder, CO 80303
Phone: (303) 444-2529 Fax: (303) 444-2563 www.bodywisept.com

BODYWISE

Patient Financial Agreement

Bodywise Physical Therapy is committed to serving our patients with professionalism and courtesy, and we expect the same from our patients. This includes being on time for your appointment and calling to cancel your appointment if you cannot make it. It also includes financial responsibility such as making your copayment or deductible payments at the time of your office visit. We accept cash, check, and all major credit cards.

Our practice accepts insurance from most major insurance companies. As a courtesy, we will verify and review you insurance coverage benefits, estimate your insurance payments, and the approximate amount of patient responsibility. Though the patient is liable for any costs not covered under his/her insurance plan, we will assist you to maximize these benefits.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary/ supplemental insurance benefits, including any referral documents from other medical providers. Current identification and insurance benefit cards are to be presented during your **first** appointment. As a courtesy to our patients, we submit all primary and secondary/supplemental claims.

FOR ALL MEDICARE PATIENTS: A doctor's referral is REQUIRED. Please present this at your first appointment to avoid any denial of claims or delay in payment.

FOR *ALL* PATIENTS: We require one upfront $25 supply fee to be paid during your FIRST APPOINTMENT.

I understand that my signature authorizes the payment of medical benefits from my insurance company to *Bodywise Physical Therapy.* My signature also authorizes the release of any medical information necessary to process my insurance claim(s).

Patient Signature: _____

Cancellation Policy

***Bodywise Physical Therapy* has a strict 24-hour cancellation policy.** This ensures that all of our patients have the same opportunity to receive the highest quality of care, service, and personal attention.

Here is our breakdown of fees for any late cancelled/no-showed appointments:

1st Late Cancel/No Show: **FEE WAIVED**
2nd Late Cancel/No Show: **$75**
3rd Late Cancel/No Show: **$90**
4th or more Late Cancel : **$100**

Print Name: _____
Patient Signature: _____ **Date:** _____

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Informed Consent for Physical Therapy Services

Physical therapy is a patient care service used to manage a wide variety of conditions. Services are provided to individuals of all ages, regardless of gender, color, religion, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury, and disability, by examination, diagnosis, prognosis, and intervention by use of rehabilitative procedures. Such procedures include but are limited to: mobilization, massage, therapeutic exercise, and dry needling. Any modalities used are focused on achieving rehabilitative and functional goals, within the realm of physical therapy.

Response to physical therapy intervention varies from person to person, therefore it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. *Bodywise Physical Therapy* does not guarantee that the treatment will help resolve the condition for which you are seeking treatment. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to refuse any part of treatment, at any time, regardless of circumstance. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, diagnosis, symptoms and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy. I agree to cooperate, participate, and comply with any physical therapy procedures within the established plan of care. **I also authorize the release of my medical information to any relevant third parties.**

Print Name: _____

Patient Signature: _____ **Date:** _____

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Automatic Payment Consent Form

Bodywise Physical Therapy **highly recommends** retaining a credit, debit, or HSA card on file for active patients. This information is kept strictly confidential in a password-locked form, and will only be used for payment of fees to *Bodywise Physical Therapy.* All patients have the option to automatically pay copays, late cancel fees, supply fees, and deductibles using this stored payment information. By providing us this necessary information, you greatly increase the amount of time spent with the physical therapist to receive the BEST patient care experience. If you would like us to allow us to bill your card automatically, please sign below.

WESTMINSTER PATIENTS---PLEASE NOTE*

STARTING TUESDAY, JULY 30, 2019--ALL WESTMINSTER PATIENTS ARE REQUIRED TO HAVE AN AUTOMATIC CONSENT FORM ON FILE WITH US. PLEASE SEE BELOW FOR EXPLANATION OF OUR CHANGE IN POLICY, AND THANK YOU IN ADVANCE FOR YOUR ASSISTANCE!

- *Due to the lack of administrative support in our Westminster location, we do require those patients to have an "Automatic Payment Consent Form" on file. This greatly assists in allowing our physical therapists to provide optimal patient care by devoting the full appointment time to the therapy itself. Any charges will be made during the same services are rendered. WE GREATLY APPRECIATE YOUR COOPERATION WITH THIS CHANGE IN POLICY!*

Credit Card Information Authorization:

I authorize *Bodywise Physical Therapy* to charge my credit, debit, or HSA card for the balance of fees. I understand that if the amount charged is greater than $100, I will be notified of the amount my card is being charged for. All receipts and itemized statements will be provided to me upon request.

Cardholder Name:

_____

Cardholder Signature:

_____

Card Number:

_____

Billing Zip Code:

_____

CVC Security Code:

_____

Expiration Date:

_____

Card Type (please circle one): VISA MASTERCARD AMEX DISCOVER HSA

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Functional Dry Needling® Consent and Request for Procedure

Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension and will promote healing. This is not traditional Chinese Acupuncture but instead a medical treatment that relies on a medical diagnosis to be effective. The Physical Therapist will not stimulate any distal or auricular points during dry needling. Your physical therapist has met requirements for **Level 2 *(54 hours of training)*** competency in Functional Dry Needling® and is a certified Functional Dry Needling® Practitioner. All training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure.

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

Risks: The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If this occurs, it may likely 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 puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands, it should not be a major concern. Other risks include: injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Procedure: I, _____, authorize practitioners of ***Bodywise Physical Therapy*** to perform Functional Dry Needling®

Please answer the following questions:

Are you pregnant? Yes No **Are you immunocompromised?** Yes No **Are you taking blood thinners?** Yes No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM*

You have the right to withdraw consent for this procedure at any time before it is performed

_____ _____ _____
Patient or Authorized Representative Signature Date Time

_____ _____
Relationship to patient (if other than patient) (Patient name printed)

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

_____ _____ _____
Physical Therapist Signature Date Time

☐ Patient was offered copy of consent and refused ☐ Patient was given copy of consent