COLUMBIA PHYSICAL THERAPY INMOTION

We would like to welcome you to Columbia Physical Therapy In Motion. Thank you for selecting our team. We are committed to provide you with the best possible physical therapy experience.

In order to make registration simple and quick, please use this checklist to make sure you have provided all necessary information and signatures. Thank you for helping us get your therapy started quickly.

New Patient Registration Checklist

CHECKLIST	
☐	Complete New Patient Registration Form (page 1-2)
☐	Family and Referral Physician's Information (page 3)
☐	Signature: Consent for Treatment (page 4)
☐	Signature: Consent for Payment Related Release of Information (page 4)
☐	Signature: Consent for Payment and Assignment of Benefits (page 4)
☐	Signature: Medicare Assignment of Benefit and Release of Information (if applicable; page 4)
☐	Signature: Consent to Use and Disclosure of Protected Health Information (If applicable; page 5)
☐	Signature: Physical Therapy Attendance Policy (page 6)
☐	Complete Medical Screening Form (page 7)
☐	Complete Body Chart to Describe your Problem (page 8)
☐	Complete Patient Specific Functional Scale (page 9)
☐	Signature: Consent for Dry Needling Procedure (page 10)

COLUMBIA PHYSICAL THERAPY *IN*MOTION

NEW PATIENT INFORMATION

Call Date_____

Scheduled Date_____

Last Name_____ First Name_____

MI_____ SSN_____ Email_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____Cell Phone_____

Date of Birth_____Gender_____ Marital Status_____

Driver's License_____

Work Related Injury: Yes / No Motor Vehicle Related: Yes / No

Auto Insurance_____

Case No_____

EMERGENCY CONTACT

Last Name_____ First Name_____

Relationship_____Contact No_____

EMPLOYER INFORMATION *(workers compensation only)*

Name_____

Address_____

City_____ State_____ Zip Code_____

Case No_____Case Manager No_____

PROBLEM

Problem Description_____Date of Injury_____

Referred By_____Referral Date_____

Referral Script: Yes / No Freqeuncy_____Duration_____

COLUMBIA PHYSICAL THERAPY *IN*MOTION

PRIMARY INSURANCE

Primary Insurance_____Phone No_____

Policy Holder's Name_____

Policy Holder's Date of Birth_____Relationship_____

ID_____Group No_____

Deductible_____Max Benefit_____

CoPay_____Coinsurance_____

Benefit Verification By_____Date/Time_____

SECONDARY INSURANCE

Primary Insurance_____Phone No_____

Policy Holder's Name_____

Policy Holder's Date of Birth_____Relationship_____

ID_____Group No_____

Deductible_____Max Benefit_____

CoPay_____Coinsurance_____

Benefit Verification By_____Date/Time_____

I authorize release of information requested by my insurance plan for payment. I understand that I am finacially responsible for any balance due. I agree to comply with the terms and conditions as outlined on the New Patient Registration Form.

Signature_____Date_____

Signature of Patient's Legal Representative_____

COLUMBIA PHYSICAL THERAPY *IN* MOTION

FAMILY DOCTOR'S INFORMATION

Last Name_____ First Name_____

Practice Name_____

Address_____

City_____ State_____ Zip Code_____

Phone No._____Fax No._____

REFERRAL DOCTOR'S INFORMATION

Last Name_____ First Name_____

Practice Name_____

Address_____

City_____ State_____ Zip Code_____

Phone No._____Fax No._____

Last Name_____ First Name_____

Practice Name_____

Address_____

City_____ State_____ Zip Code_____

Phone No._____Fax No._____

1. CONSENT FOR TREATMENT

I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist employed by or under contract with Columbia Physical Therapy in Motion, LLC.

The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment, and has witness my signature of this consent in his or her presence. The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

The physical therapist has explained that there is not guarantee that the proposed course of treatment will improve my condition and that is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I have been given on opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. If the patient is under the age of 18, a parent or guardian must sign this consent form.

Signature_____Date_____

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed evaluation and treatment have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physical therapist_____Date_____

2. CONSENT FOR RELEASE OF INFORMATION

I hereby consent to the release of information concerning my physical condition to third party payers involved in processing claims for payment of treatments administered by Columbia Physical Therapy in Motion, LLC. I consent to the use of chart information for research purposes.

Signature_____Date_____

3. CONSENT FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to Columbia Physical Therapy in Motion, LLC for any debts not covered by third party payers which are incurred during the period of time in which I am receiving treatment. I agree to forward to Columbia Physical Therapy in Motion, LLC regarding any payments received at my residence for services administered during the period I am receiving treatment. I hereby assign my/our right to receive payment for services rendered for physical therapy, Columbia Physical Therapy in Motion, LLC

Signature_____Date_____

4. MEDICARE ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION

I hereby request that payment of authorized Medicare benefits be made on behalf of Columbia Physical Therapy in Motion, LLC for any services incurred by me. I authorize the holder of medical information about me to release any information needed by the Health Care financing Administration and its agents in order to determine benefits payable in my behalf.

Signature_____Date_____

PF-2000 Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Columbia Physical Therapy In Motion or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Columbia Physical Therapy In Motion may or may not agree to restrict the use or disclosure of your protected health information.

If Columbia Physical Therapy In Motion agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Columbia Physical Therapy In Motion reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Columbia Physical Therapy In Motion to use and disclosure my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient's Legally Authorized Representative

_____
Relationship of Patient's Legally Authorized Representative to Patient

Physical Therapy Attendance Policy

Columbia Physical Therapy in Motion strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled and a fee charged for missing the appointment.

- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a fee will be charged for that appointment.

- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.

- At week's end, ALL PATIENTS, regardless of insurance/third party payor, will be charged a $50 CANCELLATION FEE for each late, late-cancelled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.

- No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.

- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.

- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits. We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of the staff at ***Columbia Physical Therapy in Motion*** appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

_____

Patient Acknowledgement/Signature Date

DATE: _____

MEDICAL SCREENING FORM

Circle YES or NO…

Have you or any immediate family member ever been told you have: .....

	Self	Family
Cancer ?	Yes ... No	Yes .....No
Diabetes ?	Yes .. No	Yes .....No
High blood pressure ?	Yes .. No	Yes .....No
Heart disease ?	Yes ... No	Yes .....No
Angina/chest pain ?	Yes ... No	Yes .....No
Stroke ?	Yes ... No	Yes .....No
Osteoporosis ?	Yes .. No	Yes .....No
Osteoarthritis ?	Yes ... No	Yes .....No
Rheumatoid arthritis ?	Yes ... No	Yes .....No

In the past 3 months have you had or do you experience:

A change in <u>your</u> health ? ..... Yes ..... No
Nausea/Vomiting ? ..... Yes ..... No
Fever/chills/sweats ? ..... Yes ..... No
Unexplained weight change ? ..... Yes ..... No
Numbness or tingling ? ..... Yes ..... No
Changes in appetite ? ..... Yes ..... No
Difficulty swallowing ? ..... Yes ..... No
Changes in bowel or bladder function ? ..... Yes ..... No
Shortness of breath ? ..... Yes .... No
Dizziness ? ..... Yes ..... No
Upper respiratory infection ? ..... Yes ..... No
Urinary tract infection ? ..... Yes ..... No

Patient Information:

Circle YES or NO…

Do you have a history of:

Allergies/Asthma ? ..... Yes ..... No
Headaches ? ..... Yes ..... No
Bronchitis ? ..... Yes ..... No
Kidney disease ? ..... Yes ..... No
Rheumatic fever ? ..... Yes ..... No
Ulcers ? ..... Yes ..... No
Sexually transmitted disease ? . Yes ..... No
Seizures ? ..... Yes ..... No

Are you currently:

Pregnant ? ..... Yes ..... No
Depressed ? ..... Yes ..... No
Under Stress ? ..... Yes ..... No

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate difficulty ☐ Only with medication

Check all that apply…

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco?

YES NO

If yes, _____Packs **X** _____Years.
Last tobacco use _____

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____

List medications currently using:

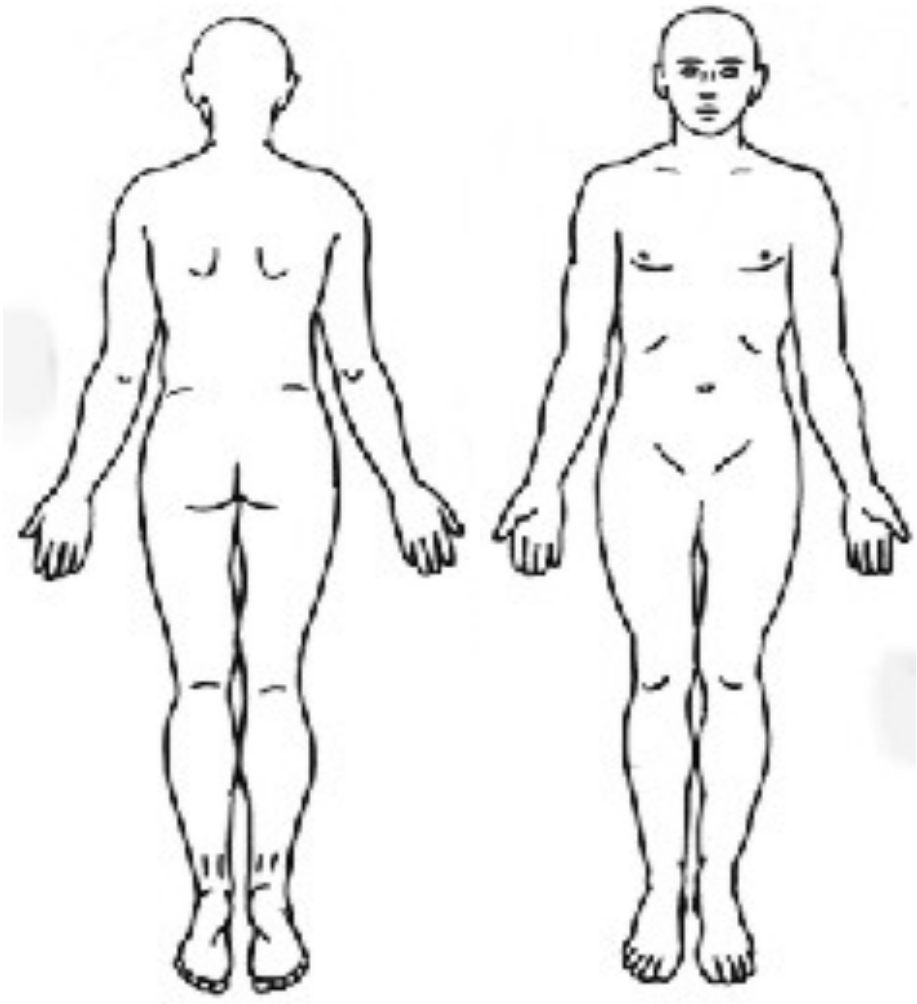
_____

_____

Signature_____

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY: Pins & Needles = 00000 Stabbing = /////
Burning = XXXXX Deep Ache = zzzzz



PATIENT SPECIFIC FUNCTIONAL SCALE (PSFS)

Read at Baseline Examination (with treating therapist):

I'm going to ask you to identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your back pain. Today, are there any activities that you are unable to do or have difficulty with because of your back? (Therapist: show scale)

Supplement: Are there any other activities that you are having just a little bit of difficulty with? For example, activities that you might assign a score of 6 or more to. List up to 2 activities.

Read at re-evaluations:

When you were initially assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list one at a time).

Today, do you still have difficulty with 1(have patient score each item); 2(have patient score each item); 3(have patient score each item); etc.

Please choose your functional tasks that you are currently having trouble to perform due to your problem(s).

Patient Specific Activity Scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity — **Able to perform activity at same level as before your (injury or problem)**

Activity	Baseline Score	6-Week Score	1-Year Score
1.			
2.			
3.			
Average:			
Supplement 1:			
Supplement 2:			
Average:			

Modified from Binkley, J: "Outcome measures for clinical use in patients with low back pain" lecture handout; Evidence-Based Practice in the 21st Century: Application to the Low Back Pain Patient, Denver, CO; April, 2000.

COLUMBIA PHYSICAL THERAPY *IN*MOTION

DRY NEEDLING CONSENT AND REQUEST FOR PROCEDURE

According to Maryland Department of Health, Board of Physical Therapy Examiners concluded that Dry Needling (as a part of manual therapy) means a physical therapy intervention, also known as intramuscular manual therapy. It involves the insertion of one or more solid needles, a mechanical device, into the muscle and related tissues to affect change in muscle and related tissues. Dry Needling can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Your physical therapist certified by Myopain Seminars has met more than minimum education and competent training requirements determined by Maryland Department of Health to perform Dry Needing. Your physical therapist performs Dry Needling in a in a manner consistent with standards set forth in the Maryland Occupational Safety and Health Act, Labor and Employment Article. Like any medical interventions, there are possible complications associated with Dry Needling. While serious complications are rare in occurrence, however, they are real and must be considered to explain to you and provide you with this consent form for Dry Needling procedure.

Risks: The most reported serious risk with Dry Needling is accidental puncture of a lung causing pneumothorax when Dry Needling was performed in precautious area, in trunk region. If this were to occur, 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 minor risks include injury to a blood vessel causing a bruise, soreness, sense of weakness, fainting, infection, and/or nerve injury. Your physical therapist has also trained competently how to avoid this type of risks with modified technique, appropriate dosage use, and monitoring patients carefully.

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 my physical therapist (Initials:_____) to perform Dry Needling to improve my current problem(s).

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

_____ _____

Patient or Authorized Representative 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 Date Time