ORTHOPEDIC SPINE THERAPY

Name:_____DOB:_____

I am happiest when I participate in these activities:

_____

I am here today because:

_____ This began:_____

What is it you want to do that you can't do now?

_____

I am taking medications for: _____ I am allergic to LATEX: YES/ NO

Previous Surgery(s):_____

GENERAL HEALTH:

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

Cancer?_____ YES / NO
Heart Condition?_____ YES / NO
Kidney Disease?_____ YES / NO
Skin Condition?_____ YES / NO
Fractures?_____ YES / NO
Metal Implants?_____ YES / NO
Diabetes? YES / NO
Pregnant (Currently)? YES / NO
High Blood Pressure? YES / NO
Seizures? YES / NO
Concussion? YES / NO
Rheumatoid Arthritis? YES / NO
Osteoporosis? YES / NO
Depression? YES / NO
Anxiety? YES / NO
Smoke? YES / NO
Pain at Night? YES / NO
Family History of Heart conditions? YES / NO
History of Stroke? YES / NO
Difficulty swallowing? YES / NO
Fibromyalgia? YES / NO
Thyroid Condition? YES / NO

NECK/JAW/HEAD:

Do you experience facial pain? YES / NO
Do you feel a click or pop when you open or close your mouth? YES / NO
Do you experience weekly headaches? YES / NO
Do you wake up with a dry mouth? YES / NO
Do you feel pain in the front of your ear, or ear "fullness" or "ringing"? YES / NO
Do you feel tension at the base of your skull when you turn your head in the upright position? YES / NO

BREATHING:

Do you snore? YES / NO
Do you have difficulty breathing with simple activity, i.e.: going up steps? YES / NO
Do you still feel tired after a full night of sleep? YES / NO
Do you have asthma? YES / NO
Do you use an inhaler? YES / NO
Do you have to sleep in an upright position? YES / NO
Have you been diagnosed with sleep apnea? YES / NO

FEET:

Do you have flat feet? YES / NO
Do you have pain on the bottom of your feet when you are standing? YES / NO
Do you have a large bony bump near either of your big toes? YES / NO
Do you have orthotics, heel lifts, or any other foot inserts in your shoes? YES / NO
Does one of your feet turn out more than the other? YES / NO
Do you feel unstable with one or both of your ankles? YES / NO

LUMBO/PELVIC/FEMORAL:

Do you ever experience small amounts of urine leakage when you cough, sneeze, laugh, lift or exercise? YES / NO
Do you ever experience small amounts of urine leakage associated with a strong sensation of needing to go to the bathroom? YES / NO
Do you experience frequent trips to the bathroom that disrupt your day or do you plan trips out based on where the bathrooms are? YES / NO
Do you experience pain, discomfort or pressure in your pelvic area when sitting or standing for prolonged periods of time? YES / NO
Do you frequently strain to have a bowel movement or to empty your bladder? YES / NO
Do you experience the sensation of pressure in your lower abdomen or pelvic region? YES / NO

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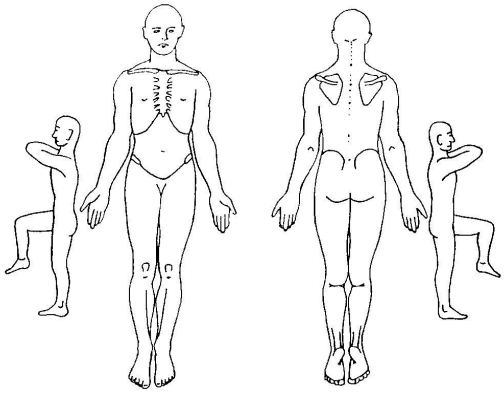
PLEASE INDICATE ON THE PICTURES TO THE RIGHT
THE LOCATION OF YOUR ISSUE(S)
&
PLEASE INDICATE YOUR LEVEL OF DISCOMFORT AT
ITS WORST AND BEST ON THE SCALE BELOW

_____

0 1 2 3 4 5 6 7 8 9 10

0 = NO DISCOMFORT 10 = EXTREME DISCOMFORT



Patient-Specific Functional Scale INITIAL or FOLLOW UP

Date of Today's PT Visit: _____

Date of Birth: _____

1. Please identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your _____problem.

**Consider these examples: getting dressed, walking your dog, yard work, sports activities, etc.

Activity	Score 0-10 (see below)	✔ Most limited
1.		
2.		
3.		

2. Please score each activity in the above chart using the scale below.

0 1 2 3 4 5 6 7 8 9 10

Able to perform activity at the same level as before injury or problem

Unable to perform activity

3. Please check (✔) above chart which of the activities is most limited today, because of your _____ problem.

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ORTHOPEDIC SPINE THERAPY

PATIENT REGISTRATION INFORMATION PLEASE

(PRINT & COMPLETE FULLY)

DATE _____

PATIENT NAME: (FIRST)_____(MI)_____(LAST)_____
ADDRESS:_____
(CITY)_____ (STATE)_____(ZIP)_____
DATE OF BIRTH:_____--_____--_____ (SEX) M / F
SS # (NEEDED FOR SOME INSURANCE)_____-_____-_____SINGLE / MARRIED / OTHER
PHONE: (HOME)_____ (WORK)_____(CELL)_____
EMAIL ADDRESS:_____
EMPLOYER:_____ (JOB TITLE)_____
STUDENT: NO / YES (Where?)_____ FULL TIME / PART TIME
EMERGENCY CONTACT:_____ (PHONE)_____ (RELATIONSHIP)_____
INJURY/ACCIDENT DATE:_____ (WORK COMP Related?) YES / NO (MVA Related?) YES / NO
IF YES, ARE YOU WORKING WITH AN ATTORNEY? YES / NO (NAME OF ATTORNEY?)_____

REFERRING DOCTOR OR DENTIST:

(FIRST)_____(LAST)_____MD / DDS / DO / DC
(CITY)_____(STATE)_____
HOW DID YOU HEAR ABOUT US?_____
IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM:_____
WOULD YOU LIKE TO BE ON OUR E-MAILING LIST? Yes / No

PRIMARY INSURANCE INFORMATION:

TYPE OF INSURANCE: WORK COMP / MEDICARE / GROUP INS / AUTO INS(MVA) / 3RD PARTY
INSURED/POLICY HOLDER NAME: (FIRST)_____(MI)_____ (LAST)_____
(RELATIONSHIP TO YOU) SPOUSE / MOTHER / FATHER / OTHER
ADDRESS:(CITY)_____ (STATE)_____(ZIP)_____
(HOME PHONE)_____(WORK PHONE)_____
(SS #)_____(DATE OF BIRTH)_____
EMPLOYER:_____
INSURANCE COMPANY NAME:_____
ADDRESS:_____
ID #:_____ GROUP #:_____
INSURANCE COMPANY PHONE #:_____

WORK COMP or MVA INFORMATION:

INSURANCE COMPANY NAME:_____
ADDRESS:_____
CASE MANAGER & PHONE #:_____
CLAIM #:_____

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Patient Consent and Billing Form

I, the patient, (or _____ for the patient), do hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment as ordered by the prescribing physician, his/her assistant(s), consultant(s), as is necessary in his/her professional judgment. I assume responsibility for discussing and understanding my proposed treatment and goals based on the evaluation with my practitioner, as well as expected benefits and potential risks and drawbacks of the evaluation and service, and understand treatment does not guarantee an improvement in patient's current condition.

I hereby authorize OST, its employees or agents, to release medical information regarding myself and my current condition(s) to my insurance company for purposes of payment and/or quality reviews; and referring, consulting, treating physicians, or other medical providers as necessary to support continuity of care. This authorization will remain valid until mutually revoked in writing by both the patient and OST. I understand that OST has made a copy of their 'Notice of Privacy Practices' available for my review, and that I can request a copy at anytime in writing or by contacting an OST office representative. I also authorize OST to utilize my contact information, such as email addresses or phone numbers, to correspond with me information not considered Protected Health Information (PHI).

****OST Patient Billing Agreement****

I, the patient, (or _____ for the patient), understand that I am responsible for communication with my insurance company regarding any copayments, deductibles, or provider information pertaining to my treatment at OST. I understand that I am responsible for obtaining any required referrals from primary care clinics. I understand I am ultimately responsible for any charges not covered by third party payers. I attest that I am not currently receiving or enrolled in home health services. I agree to notify OST in writing if I begin home health services, and acknowledge that failure to notify OST in writing will result in my being financially responsible for services rendered, up to $160 per visit. I have reviewed the various fee/payment scenarios and understand that I am responsible for all outstanding balances. I also understand that, any balance on my account over 60 days outstanding, after insurance has processed said claim(s), is subject to 3% interest fee per month; any account 90 days outstanding, or in collections for nonpayment, will assess a $50 processing fee and will require payment in full prior to further treatment. Any patient payments returned for insufficient funds will be assessed a $20 NSF fee. In addition, I understand that I am responsible for any equipment or supplies purchased specifically for my treatment, and I will be billed for any such supplies over $10.00 in value. I also understand if I schedule and fail to show for an appointment, or fail to give 1 business day notice of my cancellation, **OST may charge me a No-Show fee of $50, and after 2 occurrences may result in appointment scheduling restriction to same-day scheduling only.**

I understand that if I choose OST's 'Self-Pay' payment option, I agree NOT to solicit reimbursement from any third party payer for 'Self-Pay' services received at OST. I understand each individual 'Self-Pay' treatment purchased must be redeemed within 6 months of purchase before expiration. I also understand if I choose not to utilize self-pay in lieu of my insurance carrier, OST is not able to withdraw claims already submitted to my carrier to switch to self-pay.

I hereby agree that I, my assignees, heirs, distributees, guardians, and legal representatives will not make a claim against, sue, or attach the property of OST or any agent of OST on account of injury or damage resulting from the negligence or other acts, howsoever caused, by any employee, agent, or contractor of OST. I hereby release OST from all actions, claims, or demands that I, my assignees, heirs, distributees, guardians, and legal representatives now have or may hereafter have for injury or damage resulting from my treatment at OST.

If applicable, I authorize third party payment directly to OST of the benefits otherwise payable to me. Those charges are not to exceed the regular charges for this period of treatment. If I have sought litigation due to my injury and refuse to provide the appropriate insurance information, I understand that I am required to pay OST at the time services are provided. I also understand that if I have filed a Workers Compensation claim and my claim is denied, I will then be responsible for payment of services as they are received if I do not provide health insurance. I understand I am financially responsible to OST for charges not covered by this authorization.

Understanding your Orthopedic & Spine Therapy(OST) Health Care Costs

OST's goal is to provide you with the highest possible care at a competitive price. To help better understand potential billing scenarios, we have included a sample table with insurance processing examples below. OST accepts all major credit cards, as well as patient HSA and FSA cards. Please talk with us to better understand your specific payment options.

For patients utilizing insurance, co-payments/co-insurance will be collected and applied to this initial charge. OST does NOT accept out of network insurance; instead offers self-pay rates that are a cheaper alternative to billing out of network insurance. For those of you with out-of network plans who would like your insurance billed, you may do so on your own, but are still responsible for paying OST's self-pay cost at time of service.

For patients utilizing 'Self-Pay', please note that payment in full is due at time of service. OST will not submit any claim to insurance, and will not require insurance information of you.

Example Billing Scenario

Visit Type	Estimated Balance due to patient if your insurance plan is:						
	Out of Network	Self-Pay	In-Network with Deductible *	In-Network with Coinsurance (deductible has been met)			In-Network with Copay
				10%	20%	30%	
Initial Evaluation	$273	$130	≈ $150	$15	$30	$45	$25
Follow- up	$245	$130	≈ $120	$12	$24	$36	$25
Re evaluation	$273	$130	≈ $140	$14	$28	$42	$25

*Amount owed by patient varies by patients' insurance plan, as OST's in-network "allowed" rates vary by insurance company

**Please feel free to check with us if you would like an estimate of your expected financial responsibility after your visit.

I have read this form and I certify that I understand and agree to all terms and conditions.

Signature of Patient/Guardian: _____ **Date:** _____ **Printed Name:** _____

I agree/do not agree to OST emailing me correspondence while at OST. ❒ Agree ❒ Do Not Agree

I have read a copy of OST's Privacy Practices Statement (or waive my right to read this document), and understand my privacy rights as they pertain to my treatment at OST.

Signature of Patient/Guardian: _____ **Date:** _____ **Printed Name:** _____

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
Our office's complete NOTICE OF PRIVACY PRACTICES

Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations & other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas & as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notices of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact

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ORTHOPEDIC SPINE THERAPY

INTRAMUSCULAR DRY NEEDLING CONSENT

Intramuscular Dry Needling (IDN) 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 is instead a medical treatment that relies on a medical diagnosis to be effective. Your physical therapist trained by Myopain Seminars® has met requirements for level 4 training (130 hours of training) competency in IDN and is now considered a certified Manual Trigger Point Therapist. All training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure. IDN 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 IDN is accidental puncture of a lung (pneumothorax). 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 reinflation of the lung. This is an extremely 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.

Procedure: I, _____, authorize JOSH CADWALLADER PT, DPT, CMTPT to perform Intramuscular Dry Needling for my diagnosis of _____ _____.

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 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

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What to Expect after Intramuscular Dry Needling

Treatments How will I feel after a session of IDN?

- You may feel some soreness immediately after treatment in the area of the body you were treated. This does not always occur but should be expected and is considered normal. It can also take up to a few hours, or even until the next day, to feel an onset of soreness. The soreness may vary from person to person and based on the area of the body that was treated, but it typically feels like you had an intense workout at the gym. Soreness typically lasts 24-48 hours. Make sure to indicate to your provider at a follow-up appointment how long the soreness lasted.
- Bruising from the treatment is possible, somewhat uncommon, but is not of concern. Some areas are more likely to bruise than others including the shoulders, chest, face and portions of the extremities. Large bruising rarely occurs, but is possible. Use ice to help decrease the bruising, and if you feel concern please call us.
- It is common to feel tired/fatigued, energized, emotional, giggly or “out of it” after treatment. This is a normal response that can last up to an hour or two after treatment. If this lasts beyond a day, contact your us as a precaution.
- There are times when treatment may actually exacerbate your symptoms. This is normal and may indicate that you need to follow up sooner with your practitioner to continue treatment. If this continues past the 24-48 hour window, keep note of it, as this can help your provider adjust your treatment plan if needed based on your report. This does not mean IDN cannot help your condition.

What should I do after my treatment and what is recommended?

We highly recommend increasing your water intake for the next 24 hours after treatment to help avoid or reduce soreness. We also recommend soaking in a hot bath or hot tub to help relieve post treatment soreness, and to soften the symptoms associated with the treatment you received. After dry needling treatment, you may do the following based on your comfort level. Please note that if a particular activity hurts or exacerbates your symptoms, then discontinuing the activity is probably best.

- Work out and/or stretch.
- Participate in normal physical activity.
- Massage the area.
- Use heat or ice as preferred for post treatment soreness.
- If you have prescription medications, continue to take them as prescribed.

What should I avoid after treatment?

- Unfamiliar physical activities or sports.
- Doing more than you normally do.
- Excessive alcohol intake.

****If you are feeling light headed, or experience difficulty breathing, chest pain, or any other concerning symptoms after treatment, call us immediately. If you are unable to get ahold of us, please call your physician.**

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