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PACE WEST physical therapy

PATIENT INFORMATION Today's Date _____

Full legal name _____ Gender M _____ F _____ Other___
First Middle Last
Preferred name _____ Pronouns _____

Permanent Mailing/Billing Address
_____City_____State_____Zip_____

Best Phone # _____ Other Phone # _____

Email Address_____Date of Birth_____

Emergency Contact_____ parent spouse friend other: _____
Phone _____ Email: _____
Name of Referring Doctor : _____ Date Last Seen: _____
EMPLOYER: _____OCCUPATION: _____

How did you hear about us Doctor Insurance Plan Internet Phone Book Friend Family
Who can we thank for referring you to us? _____

PLEASE PRESENT YOUR HEALTH INSURANCE CARD TO THE FRONT DESK TO BE COPIED

Is your injury **work-related**? Yes ____ No____ **Date of Injury:** _____

Is your injury related to a **motor vehicle accident**? Yes_____ No_____ **Date of Accident:** _____

Are you represented by an attorney? Name:_____ Phone:_____

Rate the intensity of your pain: **B** = at its best **W** = at its worse **A** = average
(for example, if on your best days your pain level is 2, write the letter "B" on the 2 on the scale below)

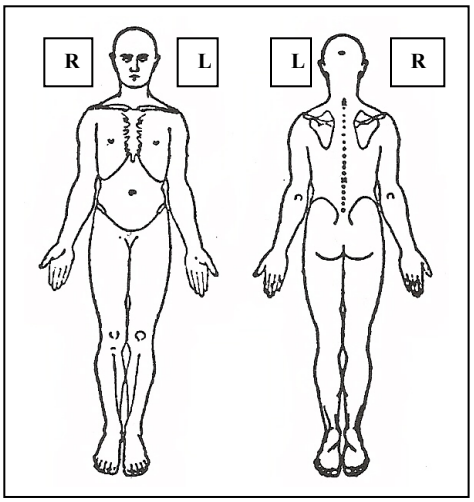
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Is your pain: Constant or does it Come and go

Is your pain getting: Better Worse Not changing

On the diagram to the right;
Please indicate where you have pain:

a. **Circle** - areas of pain
b. **XX** - areas of numbness/tingling
c. //// - areas of muscle tightness/soreness



Describe your present injury or complaint?

_____

_____

What goals do you have for Physical Therapy?

_____

_____

What position or activity eases your pain the most? _____

_____

What position or activity aggravates your pain the most?_____

_____

Date of injury/onset: _____/_____/_____

Date of surgery: _____/_____/_____ Name of Surgeon: _____

Type of Surgery:_____

MEDICAL HISTORY: Check (✓) any of the conditions below that you have experienced:

Musculoskeletal
Carpal tunnel syndrome
Fibromyalgia
Osteoarthritis
Rheumatoid Arthritis
Sciatica
Spinal Dysfunction
Sprains/Strains
Tendonitis
Thoracic Outlet Syndrome
TMJ Dysfunction

Nervous
Headaches
Multiple Sclerosis
Numbness/Tingling
Parkinson's Disease
Peripheral Neuropathy
Post Polio Syndrome
Seizures
Shingles
Stroke

Circulatory
Aneurysm
Clotting Disorder
Diabetes
Heart Attack
Heart Disease
High Blood Pressure
Pace Maker
Peripheral Artery Disease
Varicose Veins

Lymph and Immune
AIDS, HIV
Chronic Fatigue Syndrome
Edema
Hodgkin's disease
Lymphoma
Lupus

Respiratory
Asthma
COPD
Emphysema
Tuberculosis

Integumentry
Boils
Eczema
Fungal Infection
Skin Cancer
Warts

Digestive
Diverticulitis
Gallstones
Heartburn
Hepatitis
Irritable Bowel Syndrome
Ulcerative Colitis

Miscellaneous
Allergies
Cancer, other then above
Changes in Bowel Habits
Changes in Bladder Habits
Dizziness/Fainting
Fever/Chills/Night Sweats
Mental Disorder
Metal Implants
Serious Personal Injuries
Severe Night Pain
Unexplained Weight Loss

How is your general health? Poor Fair Good Excellent

What is your current stress level? Low Average High

Are you currently or have you recently taken any of the following medications? Antibiotics Anti-inflammatories Blood Thinners Heart Meds Muscle Relaxants Pain Killers Steroids

(cortisone) Other _____

Is there any chance you may be pregnant at this time? Yes No

Since the onset of this problem, have you had any of the following interventions?

Surgery MRI CT Scan X-Rays Injections Nerve Blocks Bone Scan Blood Tests Massage

Chiropractic Physical Therapy Acupuncture Other

_____

PRIVACY PRACTICE AGREEMENTS & CONSENTS

- I authorize the release of any medical information necessary to process the claim for services rendered. I further authorize payment of medical benefits directly to Pace West Physical Therapy. _____
  Patient Initials
- We stringently maintain the privacy of patient health information. A Notice of Privacy Policies is posted in the waiting room. If you wish to review our privacy practices, please ask the front desk receptionist to provide you with a copy of our policy.

- I hereby acknowledge that I consent to treatment at Pace West Physical Therapy. _____
  Patient Initials

- ***I verify that the above information is, to the best of my knowledge, accurate and complete.***

_____ _____
Patient or authorized person (signature) Date

Pace West Physical Therapy will verify coverage with your insurance company in advance of your appointment. However, it is important for you to refer to your insurance policy to verify details, including limitations, regarding your coverage for outpatient physical therapy. Insurance benefits quoted are not a guarantee of payment, but only a description of your potential benefits. Final determination of benefits will be made by your insurance company upon the receipt of submitted claims.

Patients or Guarantors are responsible for paying co-pays, co-insurance, deductibles, non-covered supplies and services, services that exceed benefit limitations, no-shows, and/or late cancellations. Copayments and payments for supplies and non-covered services are due at the time of service.

If you are treated as a result of an auto accident and have medical payment coverage, we will bill your auto insurance carrier directly. If your medical payments coverage is exhausted, we will subsequently bill your health insurance carrier. If you are treating as a result of a Worker's Compensation accident, your Worker's Compensation carrier will be billed directly. A referral from your MD or case manager is required.

Pace West Physical Therapy reserves the right to charge $83 for no-show appointments or any cancellations not made 24 hours in advance of appointment time.

If collection and/or legal services are required to obtain payment, the patient (or parent, if the patient is a minor) is responsible for all reasonably incurred costs, including attorney fees, court costs, collection fees, and interest at a rate of 1 ½% per month.

I have read the above payment policy, and I understand my responsibilities.

_____ _____
Patient or authorized person (signature) Date

MINOR CONSENT: I hereby authorize Pace West Physical Therapy to provide treatment to my **child** or ward.
Print Name: _____
Relationship:_____
Signature: _____
Date:_____

CONSENT AND RELEASE FOR TRIGGER POINT DRY NEEDLING PROCEDURE (TDN)

This form is a consent form and general release of medical liability for the TDN procedure. By signing this form, you are agreeing not to hold Pace West Physical Therapy or its staff liable for any complications that may arise from the usual application of this procedure. Prior to receiving TDN you will be "verbally consented." This means you will be asked if you want to proceed. If you state "yes," you will not be asked to sign this form again. This form will be kept on file. You may request a copy of this consent form for your records.

DESCRIPTION OF PROCEDURE: During treatment for many of our patients, we commonly use a technique called **Trigger Point Dry Needling (TDN).** In many cases, TDN can help resolve sub-acute and chronic pain. TDN may be very effective for your medical condition.

TDN involves placing a tiny acupuncture needle into the muscle in order to release shortened bands of muscle and decrease trigger point activity. This can help resolve pain, release muscle tension, and promote healing. This is **not** traditional Chinese Acupuncture, but instead, a medical treatment that relies on a medical diagnosis to be effective. All Physical Therapists at Pace West Physical Therapy have met the requirements for Level I and Level II TDN training and have years of experience in performing the procedure.

RISKS OF PROCEDURE: While complications from receiving TDN are rare in occurrence, they are real and must be considered prior to giving consent for treatment. The most serious risk associated with TDN 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 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 unless you are taking a blood thinner. *Additional possible complications include possible increased pain or other symptoms.* As the needles are very small and do not have a cutting edge, the likelihood of any significant trauma from TDN is minimal.

CHARGES FOR TRIGGER POINT DRY NEEDLING: TDN is a procedure that requires additional equipment, expertise, and liability and, in most cases, is NOT covered by health insurance. The fee for the procedure is **$30.00 per session**. This fee is in addition to your per-visit copayment, coinsurance, or deductible. There is no additional charge for TDN if you are not using health insurance coverage and are paying out-of-pocket. If your care is covered by an auto accident or liability claim, TDN will be billed to your liability insurance carrier.

Please answer the following questions: (Circle your answer)

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

Name of Patient: _____

Signature of Patient or Guardian: _____ Date: _____

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.

Therapist's Signature: _____ Date: _____

Patient Cancellation and No-Show Policy

Policy Overview: At Pace West PT we strive to provide excellent care to our patients in a timely manner. In order to do so, we have implemented the following Patient Cancellation and No-Show Policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation Policy:

- Patients are required to call **303-546-9201** or email **info@pacewestpt.com** at least 24 hours in advance to cancel an appointment. Please Note:
    - **DO NOT REPLY** to our Autoremind appointment reminder email or text. The patient must email **info@pacewestpt.com** or call 303-546-9201.
    - Appointment reminders are sent out 2 days before the scheduled appointment by text message and email
- If you need to cancel a Monday appointment, please call our office by 3:00 p.m. on the previous Friday.
- Appointments canceled less than 24 hours before the scheduled time may incur a **cancellation fee of $83.**
-

No-Show Policy:

- A "no-show" is someone who misses an appointment without canceling it in advance.
- **No-shows will be subject to a fee of $83.**
- Repeated cancelations and no-shows may result in a reevaluation of your treatment at our clinic.

Implementation:

- This policy will be communicated to patients at the time of booking their first appointment and will be included in the appointment confirmation emails.
- The front office staff is responsible for ensuring that the policy is clearly communicated and adhered to.

This policy is intended to promote efficient and effective patient care and to ensure that our patients receive the timely attention they need. Thank you for your understanding.

_____ _____

Patient Signature **Date**

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CARD CREDIT AUTHORIZATION

Pace West Physical Therapy is committed to reducing waste and inefficiency and making our billing process as simple and easy as possible. Effective September 2023, we now require that you provide a credit card on file with our office. We run our payments through our HIPAA-compliant, secure practice management software Authorize.net. Your payment information is stored on Authorize.net's secure servers for future transactions. Office personnel will not have access to your card. For your protection, only the last four digits of your card will show in our system.

- During the time you leave a credit card on file, if it expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment.
- Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.
- This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

I _____ Authorize Pace West Physical Therapy
(PATIENT NAME) (COMPANY)
to **securely store and charge** my credit card for patient responsibility via Authorize.net.

(Patients are responsible for paying co-pays, co-insurance, deductibles, non-covered supplies, and services that exceed benefit limitations according to the terms of their insurance policy/policies).

CREDIT CARD TYPE **(circle one):** VISA MC DISCOVER AMERICAN EXPRESS HSA

CREDIT CARD # _____

CARD CVC # (SECURITY CODE) _____

EXPIRATION DATE (MM/YY) _____

ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

EMAIL _____

_____ _____
SIGNATURE DATE

*****ONCE INFORMATION IS ENTERED INTO OUR SECURE & COMPLIANT SYSTEM SHEET WILL BE SHREDDED*****