Synergy Myofascial Release & Rehab, Inc.

Patient Intake and Consent Form

Today's Date:_____

First Name _____ MI _____ Last Name _____

Address_____

City_____ State _____ Zip Code _____

Home Phone _____ Date of Birth _____ Age _____

Cell Phone _____ SS# _____

Work Phone _____ Sex: Circle one: Male or Female or Other

Email _____ Marital Status: Circle one: S M D W

Area to be treated _____

Accident Related? Circle: YES or NO If yes, Circle: Auto Work Home

If yes, is there an attorney involved? YES or NO

Nature of Accident _____

Are you receiving any other physical therapy services, or any home health services? YES or NO

Responsible Party: Circle: SAME AS ABOVE

(if different)

Name _____ Address _____

City/State/Zip _____

Phone Number _____ Relationship to Responsible Party _____

Employer _____Phone _____

Address _____ City/State/Zip _____

Occupation _____ Contact Person at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

ID# _____ Group# _____ Insured Employer _____

Address _____ City/State/Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Sex: M or F or Other

Secondary Insurance _____ Insured Name _____

ID# _____ Group# _____ Insured Employer _____

Address _____ City/State/Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Sex: M or F or Other

Emergency Contact _____ Relationship_____ Phone_____

Synergy Myofascial Release & Rehab, Inc. / Patient Intake and Consent Form (cont.)

Consent for Treatment

Myofascial Release is performed in a private treatment room on a massage table. Hands on treatment requires access to patient's skin to release fascial restrictions. Patients are asked to undress to their comfort level and patient gowns are provided, along with appropriate draping, so the patient always remains covered. Modesty and personal privacy are essential parts of the treatment process.

Patient Initials _____ I have read and understand the nature of treatment as described above and request a third party sitting in the room during treatment.

Patient Initials _____ I have read and understand the nature of treatment as described above and DO NOT require a third party sitting in the room during treatment.

Treatment of Minors

I as a parent/guardian of a minor receiving treatment hereunder do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting form failure to do so. **Parent/Guardian Initials** _____

Liability

I know that Synergy Myofascial Release & Rehab, Inc. is not responsible for loss or damage to personal valuables. **Patient Initials** _____

Waiver and Release

I hereby release, discharge, and acquit Synergy Myofascial Release & Rehab, Inc., it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Patient Initials** _____

Authorization of Payment

I hereby assign all benefits directly to and also authorize release of any medical records to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for services I receive, I will be financially responsible for payment. **Patient Initials** _____

Notice of Privacy

I acknowledge receipt of Notice of Privacy Practices un the Health Insurance Portability and Accountability Act (HIPPA). **Patient Initials** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

<u>If involved in an accident (auto, work related or otherwise) please fill out section A. and B. If not involved in an accident, please fill out section B. only.</u>

(A.) MEDICAL LIEN AGREEMENT

PATIENT NAME: _____

DATE OF INJURY/INCIDENT CLAIM#: _____

INSURER/ADJUSTER CONTACT INFO: _____

_____

PROVIDER AGREEMENT

I do hereby authorize Synergy Myofascial Release and Rehab, Inc to provide _____, with prepaid copies of medical records relevant to my injury or accident.

I further authorize and direct _____ to pay directly to Synergy Myofascial Release and Rehab, Inc., such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services or reports, and/or (c) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment.

PATIENT AGREEMENT AND ACCEPTANCE

PATIENT AGREEMENT: The patient has read all the above, understands and agrees to honor all terms and conditions of this Medical Lien contract. Patient has not retained and/or consulted with an attorney. Should the Patient retain new counsel, Patient agrees to provide new counsel a copy of this Medical Lien prior to formal retention. I understand that the laws of the State of Mississippi shall govern this agreement.

DATE: _____ PATIENT NAME: _____

PATIENT SIGNATURE: _____

HOME ADRESS, CITY, STATE, ZIP: _____

Date: _____ WITNESS: _____

(B.) I fully understand that I am directly and fully responsible to Synergy Myofascial Release & Rehab for all medical bills submitted by them for services rendered to me and that this agreement is made solely for the additional protection of Synergy Myofascial Release & Rehab and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, except a recognized workers compensation case, as to the appropriateness of services provided and/or fees charged.

Date:_____ Patient Name:_____ Patient Signature:_____

Cancellation and No Show Policy

You physician has recommended physical therapy to remedy the condition that is affecting you; therefore, it is absolutely necessary that you attend all of your scheduled appointments. Your therapist will advise you at your evaluation how many times a week it will be necessary for you to attend.

Synergy Myofascial Release & Rehab Therapy requires **24 hours notice** for any cancellation. If you fail to give 24 hour notice for any cancellation, or you do not show for your scheduled appointment, an administrative fee of **$75** will be billed to you.

I, _____, have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

_____

Print Patient Name

_____

Patient Signature

Date:_____

Synergy Myofascial Release & Rehab, Inc.

New Patient Evaluation Subjective Report and Medical History

Name: _____

Date: _____

Please fill out these forms as specifically as possible to provide us with a clear picture of your present symptoms, abilities and goals.

What is the primary complaint that brings you here?

Please describe your symptoms as specifically as possible:

When did your symptoms begin?

Did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?

Have you ever received other treatments for this condition? If yes, please indicate the type of treatment, length of treatment, and effectiveness.

Physical Therapy you have received: _____

Other Treatment Services

(Chiropractor/Massages/Acupuncture): _____

What activities or positions increase your pain (please check all that apply)

__standing __sitting __walking __bending __ lifting

__ positional: _____

__other: _____

What activities or positions decrease your pain (please check all that apply)

__rest __standing __sitting __ice __ heat

__medication: _____

__ positional: _____

__other: _____

What are your goals for this treatment program? For example, what activities would you like to be able to perform better or longer?

Anything else you think we may need to know in relation to your symptoms:

Do you have any of the following medical conditions?

___ Circulatory problems
___ High blood pressure
___ Heart trouble
___ Pacemaker
___ Epilepsy
___ Diabetes
___ Pregnancy
___ Stroke
___ Cancer
___ Fibromyalgia
___ Disc disease/herniation
___ Osteoporosis
___ Blackouts
___ Visual disturbances
___ Recent or rapid weight changes
___ Headaches/Migraines
___ TMJ/jaw pain
___ Tinnitus/ringing in the ears
___ Vertigo
___ Bowel/bladder problems
___ Arthritis
___ Lymphedema
___ Radiating pain/radiculopathy
___ Trouble Bruising

Past Medical History: Please list any surgeries, traumas, accidents, or other conditions and date of occurrence.

Please list any additional symptoms that you experience monthly or more frequently:

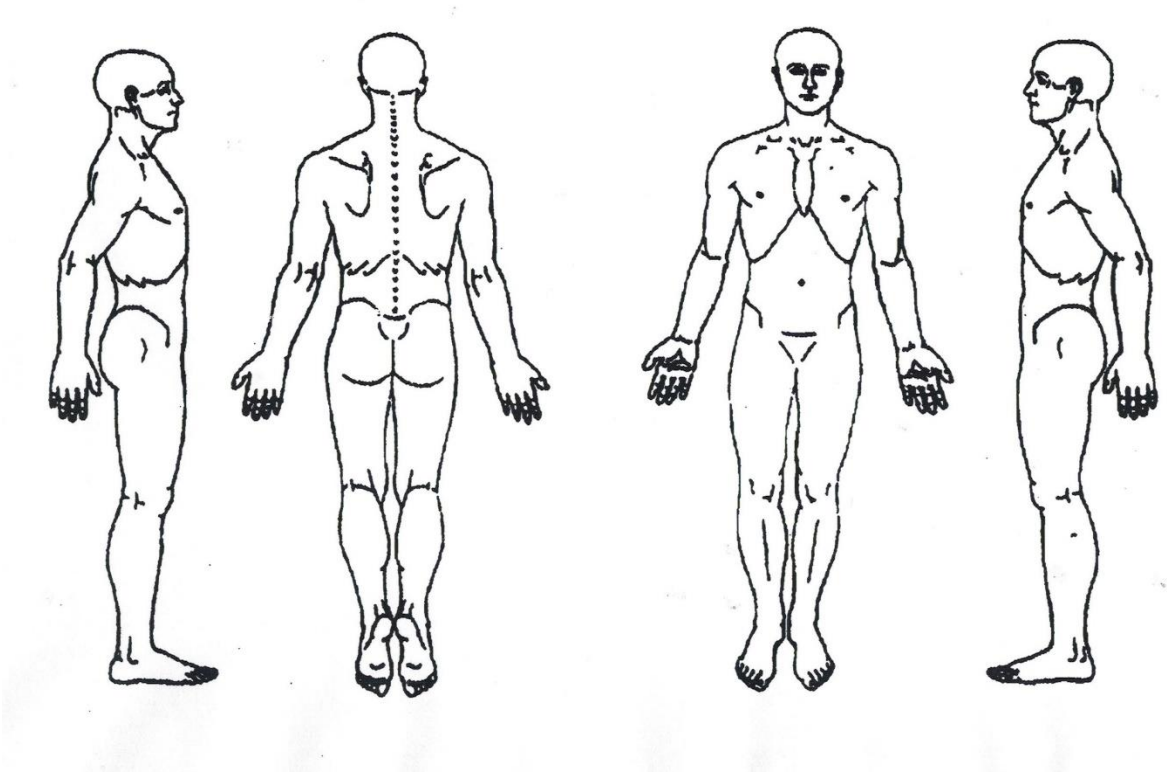
Medications:

Please list below all medications (prescription and over the counter) that you are currently taking, the problem for which you are using them, the dosage, and the effectiveness.

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
~ ~ ~ ~ ~	o o o o o	^ ^ ^ ^ ^	x x x x x	* * * * *



Name _____ Date _____

Pain assessment: 0 is no pain, 10 is worst pain you have ever experienced.

Pain today: 0 1 2 3 4 5 6 7 8 9 10

Pain when worst: 0 1 2 3 4 5 6 7 8 9 10

Patient Signature:_____

Consent for Dry Needling

PLEASE READ THIS FORM CAREFULLY

You have been diagnosed as having a muscle disorder that might benefit from dry needling therapy. Research and practice shows that dry needling can lessen muscle pain and reduce muscle tension. Dry needling therapy is not acupuncture but is similar in the sense that solid filament needles are used to penetrate the skin for therapeutic reasons. The physical therapist will be inserting the needles in places in your muscles that are causing you discomfort (trigger points: taut bands within muscles that may cause local and referred pain as well as limit movement). It utilizes the anatomical landmarks of the body to locate and treat trigger points.

You will receive the Dry Needling treatment from a physical therapist who has meet the requirements of the State Board of Physical Therapy totaling a minimum of 50 hours of directly supervised training and is credentialed by the State Board to perform this procedure.

Possible **BENEFITS** of Dry Needling are, but not limited to

- Decreased pain both locally and into referral sites
- Improved muscle function (able to contract and relax appropriately)
- Improved ability to move and function for daily activities
- Decreased muscular tension and improved myofascial flexibility

Possible **RISKS** of Dry Needling are, but not limited to

- Pneumothorax (punctured lung) if needling around/near chest wall
- Bruising
- Infection
- Extended or temporary nerve injury
- Temporary muscle soreness
- Injury to blood vessels causing a pooling of blood in your tissues

Alternative therapies that could be used instead of dry needling include, but are not necessarily limited to, the following: traditional physical therapy techniques such as manual therapy, ultrasound, electrical stimulation, therapeutic activities, neuromuscular re-education and therapeutic exercise.

I, _____, HAVE READ OR BEEN READ THE ABOVE INFORMATION. THE NATURE AND PURPOSE OF THE PROCEDURE, POSSIBLE ALTERNATIVE METHODS OF TREATMENT, RISKS INVOLVED, AND THE POSSIBILTY OF COMPLICATIONS HAVE BEEN FULLY EXPLAINED TO ME. I HAVE BEEN GIVEN OPPORTUNITY TO ASK ANY AND ALL QUESTIONS THAT I HAVE ABOUT DRY NEEDLING THERAPY. NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED. I HEREBY AUTHORIZE MY PHYSICAL THERAPIST(S) TO PROVIDE ME WITH DRY NEEDLING THERAPY.

Patient Signature _____ Relationship _____ Date_____ Time _____

I have explained the dry needling procedure to this patient or this patient's relative including its anticipated benefits, potential risks or complication, and available alternatives.