Evolution Physical Therapy, LLC

-The Evolution of Rehabilitation-

First Name: _____ Last Name: _____ M.I.: _____

What name do you prefer to go by? _____ DOB: ____ / ____ / ____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us/whom may we thank for referring you? _____

May we use your name in thanking this person? ☐ NO ☐ Yes

24 Hour Cancellation Fee: $50 - Evolution Physical Therapy requires a minimum 24 hour cancellation notification with the exception of emergencies or unforeseen illness. Any notifications less than 24 hours or no-show appointments will be subject to the Cancellation Fee. **Please initial acknowledgement of 24 Hour Cancellation Policy.** _____

Financial Responsibility: I understand that full payment is expected at the time services are rendered. Evolution Physical Therapy is not contracted with any insurance companies, but we are happy to provide you with a receipt with the necessary codes to submit to your insurance company for possible reimbursement.

Evolution Physical Therapy Fee Schedule

New patient initial evaluation exam: $155

Follow-up visits (1 hr): $140

Follow-up visits (1/2 hr): $75 (upon approval from the doctor)

Informed Consent: By signing this form, I consent to allow Evolution Physical Therapy to administer all services necessary for treatment of my condition as advisable per the judgment of my therapist. I understand and assume that exercise and rehabilitation has its own inherent risks. (Please read and review the release included). I also authorize Evolution Physical Therapy to process the credit card listed below for any charges that are in my account.

_____ _____ _____

Signature of Patient/Guardian **Print Name** **Date**

We ask that you provide a credit card number to keep on file.
Credit card numbers are stored solely on one computer in our office inside our QuickBooks database.

Credit Card # (we accept Visa/MC/Amex) _____ - _____ - _____ - _____

Exp Date: _____ / _____ Security Code: _____

Billing Address: ☐ Same as above ☐ Different (please complete below)

Address: _____ City: _____ State: _____ Zip: _____

Evolution Physical Therapy
Initial Evaluation Form

Patient's full name: _____ Date: _____

Occupation: _____ Currently Employed? ☐ Yes ☐ No ☐ Modified

Height: _____ ft _____ inches Weight: _____ lbs

Current Chief Complaint/Ailment/Injury:

Are you here for: ☐ a check up ☐ a specific problem: _____

Briefly describe how you were injured: _____

_____

Date of injury or ailment began? _____ Date of Surgery: _____

Have you consulted/received other treatments for your chief complaint? ☐ No ☐ Yes

If yes, what treatments: _____

_____

Result of treatments: _____

_____

How many visits? _____ Reason for stopping treatment? _____

Have you had any of the following? ☐ X-ray ☐ MRI ☐ CT Scan ☐ Injections | Other _____

Condition is getting: ☐ Worse ☐ Same ☐ Better | Symptoms are: ☐ Constant ☐ Intermittent

Check each box that describes the chief complaint you discussed above:

Please select your pain level on this scale: **0 = no pain - 10 =excruciating pain**

At BEST: ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 | ○ 8 | ○ 9 | ○ 10

At WORST: ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 | ○ 8 | ○ 9 | ○ 10

My complaint is: Better in the: ☐ AM ☐ MIDDAY ☐ PM ☐ Never Lessens

Worse in the: ☐ AM ☐ MIDDAY ☐ PM ☐ Constant

Does your complaint interfere with your sleep? ☐ No ☐ Yes

Are there any <u>other</u> problems/pains that you wish to address during this visit? ☐ No ☐ Yes

_____

_____

_____

_____

Evolution Physical Therapy
Initial Evaluation Form

What describes/makes your condition <u>BETTER</u>? (mark all that apply)

- ☐ Bending ☐ Movement ☐ Rest ☐ Sitting ☐ Standing ☐ Stairs
- ☐ Rising ☐ Walking ☐ Lying down ☐ Medication ☐ Ice ☐ Changing Positions
- ☐ Better in PM ☐ Better in the AM ☐ Gets better as the day progresses ☐ N/A – Cast just removed

What increases/makes your condition <u>WORSE</u>? (mark all that apply)

- ☐ Bending ☐ Movement ☐ Rest ☐ Sitting ☐ Standing ☐ Stairs
- ☐ Rising ☐ Walking ☐ Lying down ☐ Medication ☐ Changing Positions
- ☐ Coughing ☐ Sneezing ☐ Deep breath ☐ Ice/Heat ☐ Prolonged Positioning
- ☐ Worse in PM ☐ Worse in the AM ☐ Gets worse as the day progresses ☐ N/A – Cast just removed

Medical History: Please check all the apply

- ☐ Difficulty swallowing ☐ High blood pressure ☐ Epilepsy/Seizures ☐ Arthritis ☐ Diabetes
- ☐ Shortness of breath ☐ Unexplained weight loss ☐ Motion Sickness ☐ Heart trouble ☐ Stroke
- ☐ History of smoking ☐ History of drug abuse ☐ History of alcohol abuse ☐ Pacemaker ☐ Osteoporosis
- ☐ Fibromyalgia ☐ Myofascial pain ☐ Fever/Chills/Sweats ☐ Blood clots ☐ Anemia
- ☐ Bleeding Problems ☐ HIV/Hepatitis ☐ Depression/Anxiety ☐ I am currently pregnant

Previous surgeries: Type/Location _____ Year: _____

Type/Location _____ Year: _____

Medications: _____

_____

Allergies: _____

What goals would you like to achieve by the end of therapy? _____

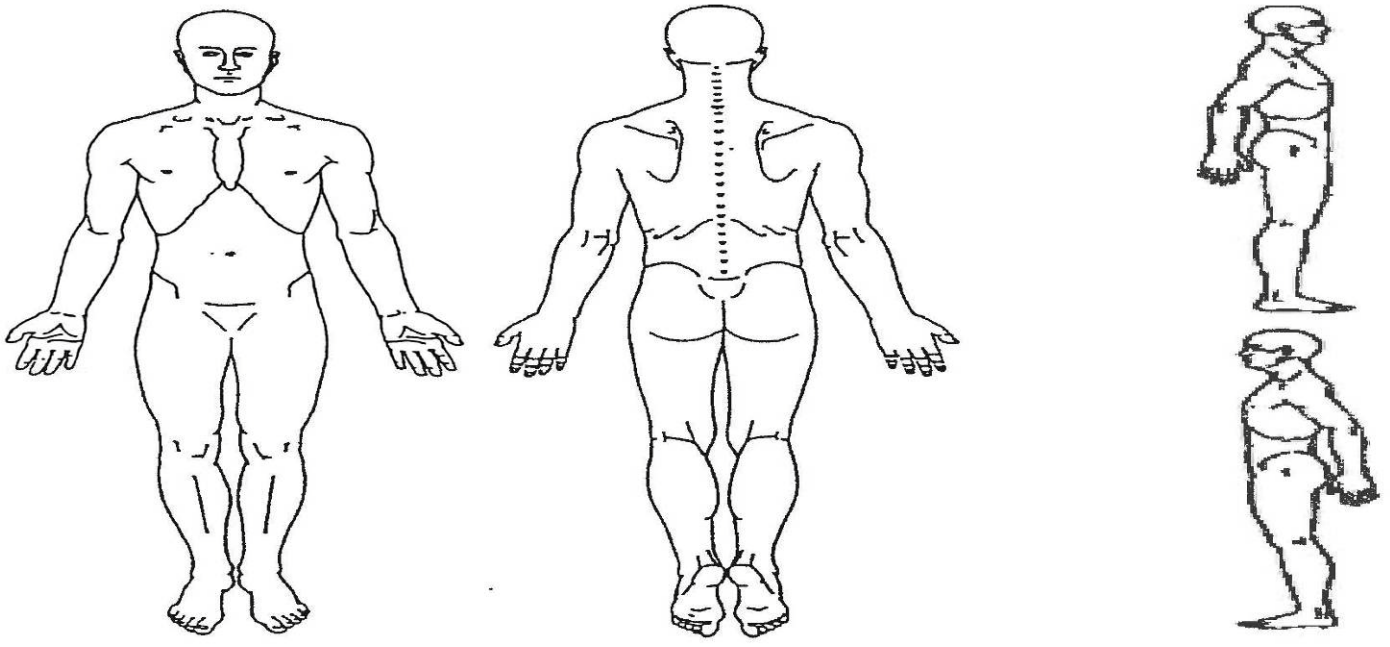
_____

Pain Diagram

Draw In Areas Of Pain On Body Diagram Using Appropriate Symbols.

Severe Pain ****** **Moderate Pain** 000000 **Dull Ache** ◇◇◇◇◇◇

Radiating Pain ↓↓↓↓↓↓ **Numbness/Tingling** XXXXXX



Evolution Physical Therapy Release Form

I acknowledge that the Evolution Physical Therapy/ Optimum Performance Training/ American Center for Biological Medicine facility include various exercise machines and free weights and rehabilitation modalities. I further acknowledge that working out on the weight machines or with free weights ("weight training") can be dangerous activity and fully realize the dangers of using the exercise machines and wrights and **FULLY ASSUME THE RISKS ASSOCIATED WITH SUCH PARTICIPATION INCLUDING** by way of example, and not limitation, the following: interference of other people in the weight room, heavy weight falling on or exerting unnatural pressure on the body, **THE RELEASESS'S OWN NEGLIGENCE**, and the possibility of serious trauma or physical injury associated with weight training.

For myself, my heirs, executors, administrators, legal representatives, assigns, and successors in interest (collectively "Successors") **I HEARBY WAIVE, RELEASE, DISCHARGE, HOLD HARMLESS, AND PROMISE TO INDEMNIFY AND NOT TO SUE** the Releases **FROM ANY** and all rights and **CLAIMS INCLUDING CLAIMS ARISING FROM THE RELEASEES' OWN NEGLIGENCE**, which I have or which may hereafter accrue to me and from any and all damages which may be sustained by me directly or indirectly in connection with weight training.

I agree it is my sole responsibility to be familiar with the various exercise machines and free weights in the Evolution Physical Therapy facility. I accept the responsibility for the condition and the adequacy of the weight training equipment provided by Evolution Physical Therapy or other building Tenants. I have no physical or medical condition which to my knowledge would endanger myself or others in the use of the various exercise machines and free weights in the Evolution Physical Therapy facility.

I agree, for myself and my successors, that the above representations are contractually binding, and are not mere recitals, and that should I or my successors assert my claim in contravention of this agreement, the asserting party shall be liable for the expenses (including legal fees) incurred by the other party or parties in defending, unless the other party or parties are finally adjudged liable on such claim for willful and wanton negligence. This agreement may not be modified orally, and a waiver of any provision shall not be constructed as a modification of any other provision herein or as consent to any subsequent waiver or modification.

Every term and provision of this agreement is intended to be severable. If any one or more of them is found to be unenforceable or invalid, that shall not affect the other terms and provisions, which shall remain binding and enforceable.

I ACKNOWLEDGE THAT BY SIGNING THIS DOCUMENT, I AM RELEASING THE EVOLUTION PHYSICAL THERAPY FACILITY, JEFFREY BERAN, AND THEIR RESPECTIVE AGENTS, EMPLOYESS, AND AFFILIATES (COLLECTIVELY "RELEASEES") FROM LIABILITY. THIS RELEASE FORM IS A CONTRACT WITH LEGAL CONSEQUENCES. I HAVE BEEN ADVISED TO READ IT CAREFULLY BEFORE SIGNING.

Signature of Patient/Guardian	**Print Name**	**Date**

Consent and Release of Parent or Guardian if Participant is a ***minor***:

I am the parent or legal guardian of _____ My child is fit to use exercise machines and free weights. I consent to my child's use of the exercise machines and free weights. **I HAVE READ AND I UNDERSTAND THIS RELEASE AGREEMENT.** In consideration of allowing my Child to participate, I consent to it ad agree that **ITS TERMS SHALL LIKEWISE BIND ME, MY CHILD,** my heirs, legal representatives, and assignees. **I HEREBY RELEASE AND SHALL DEFEND, INDEMNIFY AND HOLD HARMLESS THE RELEASEES FROM EVERY CLAIM AND ANY LIABILITY** that I or my Child may allege against the Releases (including reasonable attorneys' fees or costs) as a direct or indirect result of injury to me or my Child because of my Child's participation, **WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES** or others. **I PROMISE NOT TO SUE RELEASESS** on my behalf of my Child regarding any claim arising from my Child's participation in weight training and rehabilitation services.

Signature of Parent/Guardian	**Print name of Parent/Guardian**	**Date**

TRIGGER POINT DRY NEEDLING CONSENT FORM

Trigger point Dry Needling involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility and circulation of the muscle and therefore decreasing the symptoms.

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

TDN is NOT Acupuncture in that, it is not based on Eastern or Chinese Medicine and distal meridian points or auricular (ear) points are not stimulated purposefully. Only trigger points / tender points biomechanically or neuromyofascially related to your dysfunction will be needled.

Risks of the procedure:
Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only 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 lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and does not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Infrared Laser Therapy Consent Form

Laser Therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilatation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:

- Temporary increase in pain during application of laser.
- Temporary increase in pain the following day after laser therapy.
- Mild bruising from vasodilatation or direct pressure from laser tip.
- Temporary dizziness
- Reaction when photosensitizing drugs are used with laser therapy.

Initialing below does not mean you HAVE to receive these treatments. You can speak to the doctor first before deciding. Initialing now eliminates the need to resubmit an updated form in the middle of your session. However, if you are not comfortable with the information above, the decision to decline treatment is your right.

Do you have any known disease or infection that can be transmitted through bodily Fluids? ☐ Yes ☐ No

Are you or could you possibly be pregnant? ☐ Yes ☐ No

Are you currently taking Anticoagulant medications (Blood Thinners) ☐ Yes ☐ No

If you marked yes to any of the above, please discuss with your practitioner.

I understand the risks associated with these treatment options outlined by my doctor and **consent** to (initial): _____ Needling _____ Laser

_____	_____	_____	_____
Signature of Patient/Guardian	**Print Name**	**Date of Birth**	**Date**

☐ **I was offered a copy of this consent and refused treatment using BOTH needling and laser therapy.**

HIPPA Health Care Authorization Form (Privacy Practices)

All information you provide us with is confidential in nature and will only be referenced or shared with you, insurance companies, providers and billing or legal facilities who provide us with a signed request. By signing this form I give permission to **Dr. Jeff Beran PT, DPT, ATC's** Office to use all information I provide, as this office deems appropriate. This consent shall be in force and effect as long as I am a patient at this practice. In addition, I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician at this practice.

In addition, by signing below I give this office permission to:

- Send me correspondence and provide me with health & other related information.
- Call and/or leave messages for me on an answering machine and/or voicemail.
- Provide health care professionals & others with my information when requested.
- Allow staff and other patients to view my name on the sign in register/sheet.
- Treat me in a semi-open room where others may see me if passing by in the hall.
- File a health care provider lien to bind insurance companies to forward payment.
- Display any testimonials I may write.
- Forward to/request my records from providers, attorneys & insurance companies.
- Speak to my insurance company on my behalf.

I am aware other persons in this office may overhear my protected health information during the course of care. I also understand my information may be overheard by other patient's at the front desk or in other areas of the office. Should I need to speak with the doctor privately at any time, the doctor will provide a room for these conversations.

I authorize the following individual(s) to have access to the information on my account: SELECT ONE OPTION

☐ Anyone calling on my behalf requesting appointment & billing information

☐ These people specifically (spouse, parents, sibling, children, office assistants, accountants, etc)

_____ _____

_____ _____

_____ _____

☐ I do not authorize anyone but myself to have access to my information at this office.

Per HIPAA rules and regulations, unencrypted email is not considered a secure way of communication. EPT uses email communication to send treatment videos, payment receipts, & appointment reminders.

Please initial that you understand the information above concerning emails from EPT: **Initials:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

Please feel free to read the binder provided at the front reception desk. I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges:

- I have the right to review the notice prior to signing this consent.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

The patient identified below authorizes Dr. Jeff Beran PT, DPT, ATC's office to use and disclose protected health information in accordance with all items described. This authorization shall expire on the following date: *No Expiration Date*

_____ _____

Print name of Patient **Patient Date of Birth:**

_____ _____ _____

Signature of Patient/Guardian **Print name of Guardian (if applicable)** **Date**