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PHYSCIAL THERAPY + WELLNESS

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Date: _____

Height: _____ Weight: _____ Age: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact # & Name _____

Check Yes or No if you have been diagnosed with any of the following. Please also indicate if an immediate family member has been diagnosed.

	Yes	No	Family		Yes	No	Family
Asthma				History of Cancer			
Alzheimer's				Immunosuppression			
Autoimmune Disease				Migraine/Headaches			
Cardiovascular Disease				Multiple Sclerosis			
Cauda Equina Syndrome				Muscular Dystrophy			
Current Infection				Osteoarthritis			
Diabetes Type I or II				Osteoporosis			
Fibromyalgia				Parkinson's Disease			
Fracture				Rheumatoid Arthritis			
Heart Attack				Stroke			
High Blood Pressure				Traumatic Brain Injury			
Other (please explain):							

Infinity Health Physical Therapy and Wellness, LLC
484 Old Corvallis Road Suite B
Hamilton, MT 59840
Phone: 406-381-3683 Fax: 406-215-1616

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In the past 3 months have you had any of the following symptoms?

	Yes	No		Yes	No
Nausea/Vomitting			Difficulty Sleeping		
Angina/Chest Pain			Shortness of Breath		
Unexplained Weight Loss			Numbness/Tingling		
Fever/Chills/Sweats			Change in Bowel/Bladder		
Loss of Appetite			Difficulty Swallowing		
Dizziness			Change in Health		

Do any of the following apply to you (circle yes or no)?

Allergies	Yes	No	List:_____
Seizures	Yes	No	Explain: _____
Pacemaker	Yes	No	
Any metal in your body	Yes	No	Where: _____
Pregnant	Yes	No	# of Weeks: _____
Blood disorder	Yes	No	Explain: _____
Depression	Yes	No	
Anxiety	Yes	No	
Other mental illness	Yes	No	Explain: _____
Drink Alcohol	Yes	No	How many drinks/week: _____
Tobacco Use	Yes	No	Type and Amount: _____
Vision Difficulties	Yes	No	Explain: _____
Hearing Difficulties	Yes	No	Explain: _____
Speech Difficulties	Yes	No	Explain: _____

List previous **surgeries and dates**.

_____
_____
_____
_____

List recent and previous **imaging** (x-ray, MRI, CT) body region and date.

_____
_____
_____
_____

List **medications** (prescriptions, OTC, and supplements) you are currently using.

_____
_____
_____
_____

Rate your **level of pain** based on the scale below:

Current/Resting: _____
Worst last 3 days: _____
Best last 3 days: _____

Is your pain (check one):

____ getting better ____ getting worse ____ staying about the same

How did you hear about us? _____

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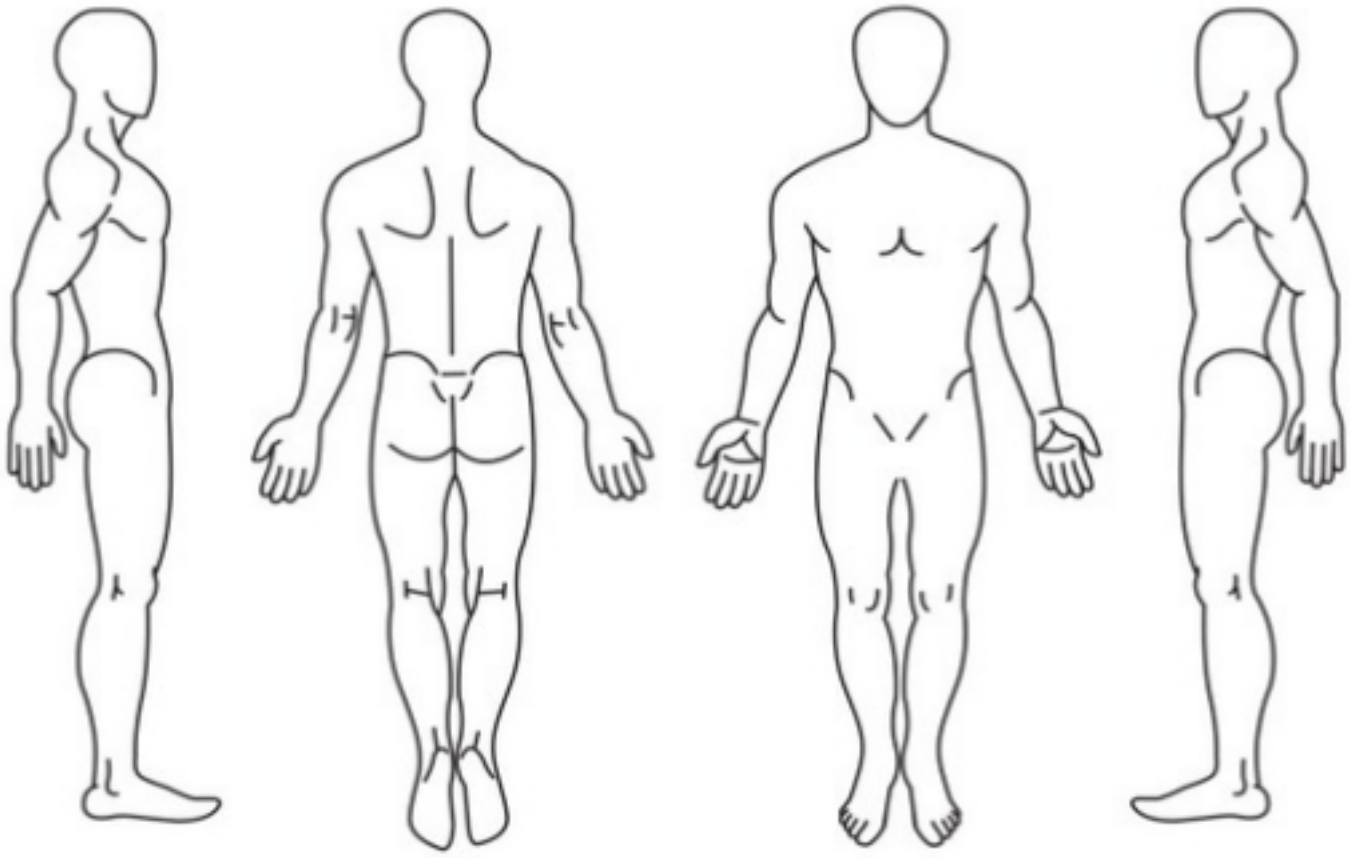
Name_____ Date_____

Please mark on the body chart where you have pain. If you have multiple areas of pain, please put a 1 by your primary pain and 2 by your secondary pain, etc for each area.



Please briefly explain the history of your current pain and reason for seeking treatment:

_____

_____

_____

_____

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HIPAA - Notice of Privacy Practices

Congress passed the Health Insurance Portability and Accountability Act, or HIPAA, in 1996. Its primary purpose is to ensure that people who change jobs cannot be denied health insurance in a new job because of a pre-existing health condition. The law also established minimum standards of privacy and security to ensure that sensitive information about individuals' health would remain confidential.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Infinity Health Physical Therapy and Wellness, LLC's HIPAA - Notice of Privacy Practices form. I acknowledge that I have been given an opportunity to review the HIPAA - Notice of Privacy Practices form and have all questions answered. I acknowledge that I may request a copy of the form at any time. _

CANCELLATION POLICY

Infinity Health Physical Therapy and Wellness requires patients to be on time and give notice for any cancellations or tardiness. We rely on patients to be accountable for their appointment time and follow our cancellation policy to ensure we are able to deliver the best possible care.

Please give **>24 hours notice** for any known cancellation. In the event of an emergency or illness, we allow 1 cancellation with <24 hours notice without any penalty over a 30 day time period. If a patient has **2 or more** cancellations in <30 days, we require a **$35 fee** paid by the patient at their next appointment.

In the event of a **no show**, we will allow 1 accidental missed appointment. If the patient has **2 or more** no shows in a 30 day time period, we require a **$35 fee** paid by the patient at their next appointment.

Patient was offered a copy of this policy on the date signed. Infinity Health Physical Therapy and Wellness has the right to modify this policy at any time for any reason without notice.

Signature: _____ Date: _____
Printed Name (Parent/Guardian and Minor): _____

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PAYMENT POLICY

Thank you for choosing Infinity Health Physical Therapy and Wellness as your physical therapy provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. It is also your responsibility to know whether or not pre-authorization is required, and if it is, it is your responsibility to get your treatment pre-authorized. Please contact your insurance company with any questions you may have regarding your coverage.

2. Self Pay, Copays, and Deductibles: All copays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copay at each visit. If you have no insurance, we do expect payment at the time of service unless you have made other arrangements with our billing department. For minor patients, the parent, relative, or other individual, escorting the patient is responsible for any payments due at the time of service and for the balance remaining after insurance has processed your claim.

3. Non-covered Service: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of service.

4. Proof of Insurance: All patients must complete our patient information form before seeing a therapist. We must obtain a copy of your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges you incur.

5. Claims Submission: Infinity Health Physical Therapy and Wellness will attempt to obtain payment from your insurance carrier, worker's compensation plan, or motor vehicle insurance. It is our policy to complete an initial claim form and submit it to your carrier. We will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that

the balance of your claim is your responsibility whether or not your insurance company pays your claim. If monthly payments are required, please speak with our billing department.

6. Coverage Changes: If your insurance changes, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment: I understand that I am personally responsible for paying all collection fees associated with my account, including reasonable attorney fees and reasonable collection agency fees. I understand that in the event my account is turned over to a third party collection agency, a collection fee in the amount of up to 50% of my total account balance will be added to my balance and that I am responsible for paying my total account balance plus the collection fee.

8. Non-Sufficient Funds Checks: Our policy is to attempt to secure funds from all checks written. If they fail on the first attempt, our bank will automatically send your check through a second time. If it is returned to us we charge our bank fees. The check would need to be covered by cash, credit card, or money order within 5 business days of our notice or it may be presented to our collection agency.

9. Authorization and Assignment of Benefits: By signing below I hereby assign, transfer, and set over to Infinity Health Physical Therapy and Wellness and/or its individual therapists, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information required to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Thank you for reviewing our payment policy. Please let us know if you have any questions or concerns. I have read and understand this payment policy, including the Notice of Privacy Practices and the Assignment of Benefits, and I agree to abide by its terms:

Signature: _____ Date: _____
Printed Name (Parent/Guardian and Minor): _____

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FUNCTIONAL DRY NEEDLING CONSENT TO TREAT

Functional dry needling (FDN) is a specific type of treatment performed by a certified functional dry needling specialist, typically a physical therapist. The treatment is used to assist the physical therapist in **reducing the patient's pain and muscle guarding** while improving functional mobility. The tool used for FDN is a very small diameter needle or acupuncture needle. The needle is used to penetrate the affected muscle and then stimulate a relaxation response, typically resulting in a muscle twitch. Electrical stimulation may be applied during FDN to improve muscle response.

Please review the following items to see if you have any precautions or contraindications to the treatment. Circle yes or no.

1. Are you taking any blood thinners?	Yes	No
2. Do you have a blood condition or blood borne virus?	Yes	No
3. Have you had surgery in the last 12 weeks?	Yes	No
4. Have you had laminectomy in your neck or back?	Yes	No
5. Do you have a history of cancer?	Yes	No
6. Are you or could you be pregnant?	Yes	No
7. Do you have any known autoimmune diseases?	Yes	No
8. Have you been diagnosed with osteoporosis?	Yes	No
9. Do you have scoliosis?	Yes	No
10. Do you have a pacemaker?	Yes	No
11. Do you have any respiratory illness?	Yes	No
12. Do you have an active infection?	Yes	No

There are always risks involved with inserting a needle into tissue. Although the risks are low and unlikely, it is important to review them prior to treatment. Potential risks and side-effects include: infection, pneumothorax, nerve injury, bleeding, bruising, muscle ache, lightheadedness, nausea, and dizziness.

Signature: _____ Date: _____

Printed Name (Parent/Guardian and Minor): _____

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FUNCTIONAL DRY NEEDLING PATIENT INFO

WHAT TO EXPECT DURING A SESSION:

The treating physical therapist will perform a movement screen along with special tests to determine best treatment for each patient. The therapist will review the risks and benefits and determine if the patient is a candidate. At this point, the PT will prepare the patient for treatment by positioning them on the treatment table and prepping the area to be treated. The PT will use clean technique by always wearing medical gloves, swabbing the treatment area with rubbing alcohol, using sanitizer on the gloves, and using sterile single use needles which are then discarded into a sharps container after removal.

WHAT DOES IT FEEL LIKE?:

The PT will inform the patient prior to needle insertion with a 1, 2, 3 count. It helps to be completely relaxed during the entire session. The PT will confirm the area by first placing her hand on the area and then inserting the needle. Most people explain it as a slight poke at insertion and then a deep ache once into the muscle. The treatment is typically quite tolerable and most patients report the benefits outweigh any discomfort felt during the treatment. Once the needle is in the painful area, the muscle may twitch or contract which is the release of the trigger point. Your PT may choose to use electrical stimulation, as well, to help the muscle relax and relieve any pain or inflammation. The entire treatment usually only lasts 2-5 minutes. Some results are immediate which may include pain relief, decreased inflammation, muscle relaxation, and/or increased flexibility.

HOW WILL IT FEEL AFTER A SESSION?:

It is fairly common to have some muscle soreness in the area treated for 24-48 hours after a session. Most patients describe this as a soreness similar to that of performing a new workout routine and feeling sore the next day. On occasion, patients may report other symptoms such as feeling tired, silly, or lightheaded. Bruising may occur, but usually goes away within a few days.

WHAT TO DO TO MANAGE POST TREATMENT SORENESS:

Using heat after a session, rather than ice, may help ease soreness. It is also encouraged that you perform some kind of light to moderate exercise to improve blood flow to the area. Try to avoid "overdoing it", especially now that the pain is reduced. It may help to take an over the counter Tylenol or NSAID if you are able. If symptoms last >48 hours, please contact Infinity Health to discuss with your PT.

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PATIENTS WITHOUT INSURANCE
Self/Direct-Pay

By signing below I state that I or the minor patient DO NOT have health insurance and will be responsible for services rendered here at Infinity Health Physical Therapy and Wellness. I agree to pay Infinity Health Physical Therapy and Wellness the full and entire amount of treatment given to me or to the above named patient at each visit.

Signature: _____ Date: _____
Printed Name (Parent/Guardian and Minor): _____

ADULT CONSENT TO TREAT FOR A MINOR

Child's Name: _____ Date of Birth: ___ / ___ / ___ Age: _____
Parent/Guardian Name: _____ Phone #: _____
Address (if different than minor): _____
Date of Birth: ___ / ___ / ___ SS #: _____ Relationship to Child: _____
Employer: _____ Work Phone #:_____

I _____, hereby authorize Infinity Health Physical Therapy and Wellness and/or it's Individual Therapists to evaluate and administer physical therapy treatments to _____. This authorization is in effect as of this _____ day of _____, 20____. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all services rendered to the above patient whether I am present at the time of treatment or not.

Parent/ Guardian Signature: _____ Date: _____._

Infinity Health Witness Signature: _____ Date: _____