INSTRUCTIONS:

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Patient Information Consent Form

Consent to Physical Therapy Evaluation and Treatment Cryo and Normatec

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by MOVE Human Performance and Physical Therapy LLC and Move Human Performance Center LLC. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Financial Arrangements, Assignment of Benefits, and Insurance Proceeds

I agree to the following terms related to payment for services provided by the facility. I hereby individually obligate myself to pay the account of the facility in accordance with the regular rates and terms of the facility. However, if I am eligible to receive benefits under an insurance or health care service plan with which the facility has contracted, I shall not be obligated to pay for services covered under the plan which are paid for pursuant to the contract, with the exception of plan deductibles, coinsurance or copayments.

I authorize payment of medical benefits to MOVE Human Performance and Physical Therapy LLC and Move Human Performance Center LLC for services rendered. Each will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy. **I acknowledge that any amounts not paid by my insurance are my responsibility.** Should my account become delinquent and be referred to any attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law.

Patient Information Consent Form (HIPAA)

I have read and fully understand MOVE Human Performance and Physical Therapy, LLC and Move Human Performance Center LLC Notice of Information Practices. I understand that. MOVE Human Performance and Physical Therapy LLC and Move Human Performance Center LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that MOVE Human Performance and Physical Therapy LLC and Move Human Performance Center LLC will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in MOVE Human Performance and Physical Therapy, LLC and Move Human Performance Center LLC Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point MOVE Human Performance and Physical Therapy, LLC and Move Human Performance Center LLC has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Patient Consent to be on video and or photos

I hereby authorize MOVE and/or clients to video, take pictures, and post on social media sites. MOVE has made me aware of security measures with video or picture caption.

LATE CANCEL / NO SHOW POLICY

Please call our office if you cannot come to an appointment already scheduled. If you do not call at least 6 hours (during business hours) prior to your appointment time, there will be a $25 late cancel fee. Failure to call or show for an appointment will result in a $50 No Show fee.

Patient Signature/Legal Guardian ____ Date______________________

Patient Information Form

Patient Information

Patient Name: ____________ DOB: ____________ Sex: ____________

Driver's License: ____________ SSN: ____________

Home Phone: ____________ Cell: ____________

Address: ____________

Employer: ____________ Position: ____________

Employer Address: ____________ Phone No. ____________

Emergency Contact Information

Dependent? ____________ If yes, Guardian's Name: ____________

Guardian's Phone: ____________ Cell: ____________

Marital Status: ____________ Spouse's Name: ____________

Spouse's Employer: ____________ Work Phone No. ____________

Emergency Contact: ____________ Relationship: ____________

Home Phone: ____________ Cell: ____________

Emergency Contact: ____________ Relationship: ____________

Home Phone: ____________ Cell: ____________

Insurance

Insured Party: ____________ Relationship to Patient: ____________

Insurance Company: ____________ Phone No. ____________

Address: ____________ Insurers DOB (mm/dd/yyyy): ____________

Policy No. ____________ Group No. ____________

Dual Coverage? ____________ 2nd Insurance Company: ____________

Insured Party: ____________ Relationship to Patient: ____________

Phone No. ____________ Address: ____________

Policy No. ____________ Group No. ____________

Payment Method: ____________ Card/Check No. ____________

I hereby authorize payment of medical benefits billed to my insurance by ABC Physicians. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibly for payment for any service(s) provided to me that is not covered by my insurance.

I agree to all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if ABC Physicians do not participate with my insurance.

I hereby authorize ABC Physicians to use/or disclose my health information that identifies me or which can be reasonably used to identify me to carry out any treatment payment and healthcare treatment plans.

I understand that while this consent is voluntary, ABC Physicians can refuse to treat me if I refuse to sign this consent form. I understand this authorization can only be revoked in writing. If I withdraw my consent, such revocation will not affect any actions ABC physicians took before receiving my cancellation.

____________________ ____________

Patient or Guardian Signature Date

____

Patient Printed Name

Physical Therapy Intake Form

Personal Information

Name: ______________________________ Date: ______________

Address: ______________________________

Phone: ______________________ Email: ______________________

DOB: ______________________ Sex: ______________________

Who referred you? ______________________________

History

Exercise Frequency: __________________ Exercise Type(s): ______________

Do you smoke? __________ Have you ever smoked? ________ How Often? ________

Are you pregnant? __________________ Do you have a Pacemaker? ____________

Allergies: ______________________________

What medications are you currently using? ______________________________

Previous complaints/surgeries: ______________________________

Previous diagnoses/medications: ______________________________

Complaint

What is your major complaint? ______________________________

Start Date: ____________________ Possible Cause: ______________________

Symptoms: ______________________________

Previous doctors seen for complaint: ______________________________

Previous treatment for complaint: ______________________________

Symptom-Aggravating Factors: ______________________________

Symptom-Relieving Factors: ______________________________

Time of Day Symptoms are Best: __________ Time They Are Worst: ______________

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

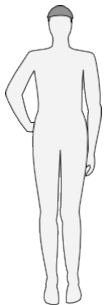
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

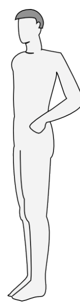
Is your pain getting better or worse? ______________ Have you had this injury before? ________

Do You Have Any of the Following Today? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Areas of Discomfort





______________________________ ______________________

Patient or Guardian Signature Date

____

Patient Printed Name

By willingly choosing to come to MOVE Human Performance Center/MOVE Human Performance and Physical Therapy, you agree to release MOVE, other clients/patients, and any staff member of any and all liability to potential risk of contracting and/or spreading COVID-19.

In order to ensure the safety to our clients, patients, and staff measures have been implemented at MOVE that include the following:

- Limited occupancy
- Cleaning and sanitizing all areas in use on a consistent and regular basis.

Therefore, under the terms of this release and sufficiency of which is hereby acknowledged, do hereby release and forever discharge MOVE-including their agents, employees, successors and assigns, and their respective heirs, personal representatives, affiliates, claimed to be liable, whether or not herein named, none of whom admit any liability to the undersigned, but all expressly denying liability, from any and all claims, demands, damages, actions, causes of action or suits of any kind or nature whatsoever, which I now have or may hereafter have, arising out of or in any way relating to any and all injuries and damages of any and every kind, to both person and property, and also any and all injuries and damages that may develop in the future, as a result of or in any way relating to the potential or actual acquisition and spread of COVID-19.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND FULLY UNDERSTAND ITS CONTENT. TO THE BEST OF MY KNOWLEDGE, I AM NEITHER A CARRIER OF THE COVID-19 VIRUS NOR AM I SYMPTOMATIC AT THIS TIME. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Participant's Printed Name:____

Participant's Signature:____

Date:____________

Recorded Temperature:______

This release is constructed broadly to provide a release and waiver to maximum extent permissible under applicable law.

Integrative Dry Needling Consent Form

Integrative Dry Needling involves placing a small needle into the tissue that is tender with the intent to normalize the physiology of the area and regain homeostasis, which will improve the function of the musculoskeletal system resulting in symptom reduction.

Integrative Dry Needling 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.

Risks of the procedure:
Though unlikely there are risks associated with the treatment. The most serious risk associated with Dry Needling is accidental puncture of a lung (pneumothorax). If there 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 do not have a cutting edge, the likelihood of any significant tissue trauma from Dry Needling is unlikely.

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

Please circle the appropriate answer:

- Do you have any known disease or infection that can be transmitted through bodily fluids?
  Yes **No**

If you marked yes, please discuss with your practitioner.

____
Please print your name

____
Signature Date

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PATIENT RIGHTS

- R9-10-1008 Patient Rights
- An administrator shall ensure that:
  - The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on premises;
  - At the time of admission, a patient or patient's representative receives a written copy of the requirements in subsection (B) and the patient's rights in subsection (C); and
  - Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
    - How and when a patient or the patient's representative is informed of patient's rights in subsection (C); and
    - Where patient's rights are posted as required in subsection (A) (1).
- An administrator shall ensure that:
- A patient is treated with dignity, respect, and consideration;
- A patient is not subjected to:
  - Abuse;
  - Neglect;
  - Exploitation;
  - Coercion;
  - Manipulation;
  - Sexual Abuse;
  - Sexual Assault;
  - Except as allowed R9-10-1012(B), restraint or seclusion;
  - Retaliation for submitting a complaint to the Department or another entity; or
  - Misappropriation of personal and private property by an outpatient center's personnel member, employee, volunteer or student; and
- A patient or a patient's representative:
  - Except in an emergency, either consents to or refuses treatment;
  - May refuse or withdraw consent for treatment before treatment is initiated;
  - Informed of the following:
    - The outpatient treatment center's policy on health care directives, and return
    - The patient complaint process;
  - Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted an outpatient treatment center for identification and administrative purposes; and
  - Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
    - Medical Records, or
    - Financial records.
- A patient has the following rights:
  - Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
  - To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
  - To receive privacy in treatment in care and personal needs;
  - To review, upon written request, the patient's own medical record according to A.R.S. 12-2293, 12-2294, 12-2294.01;
  - To receive a referral to another healthcare institution if the outpatient treatment center is not authorized or not able to provide physical health services behavioral health services needed by the patient
  - To participate or have the patient's representative participate in the development of, or decisions concerning treatment;
  - To participate or refuse to participate in research or experimental treatment; and
  - To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.