INSPIRE
physical therapy

1451 Greens Prairie Rd W, Ste 100
College Station, TX 77845
979-690-2478

(located on South College Station beside Discount Tire and behind Walgreens and Caprock ER)

Name (Please Print): _____

Address_____

City_____ State_____ Zip_____

Date of Birth_____

Student: Not a student _____ Yes, part-time_____ Yes, full-time_____

Employer: _____

Home Phone_____

Work Phone_____

Cell Phone_____

Email Address_____

Would you like appointment reminders sent via phone?_____ email?_____ text?_____

Would you like a Christian prayer of blessing over your treatment? Yes_____ No_____

Insurance Information:

Primary Insurance_____ ID#_____

Insured's Name:_____ Relationship to patient:_____

Date of Birth: _____ Social Security Number: _____

Address (if different from patient's): _____

Secondary Insurance (if applicable)_____ ID#_____

Insured's Name:_____ Relationship to patient:_____

Date of Birth: _____ Social Security Number: _____

Address (if different from patient's): _____

Referring Physician_____

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MICHAEL PERKINS, PT

Outpatient Medical History/Screening Form

Patient_____ Family Physician/Internist_____

Emergency contact (and telephone #) _____

How did you hear about Inspire PT? _____

Medical Information: *Please check all that apply*.

To the best of your knowledge do you have or have you had:

1. High blood pressure_____
2. Chest pain/Heart attack_____
3. High cholesterol_____
4. Pacemaker_____
5. Shortness of breath_____
6. History of smoking_____
7. Lung problems_____
8. Emphysema/Asthma_____
9. Bleeding/Bruising_____
10. Anemia_____
11. Diabetes_____
12. Hypoglycemia_____
13. Lightheadedness/Dizziness_____
14. Blood disorders_____
15. Concussions_____
16. Fainting disorders_____
17. Anxiety/Panic Attacks_____
18. Arthritis/Joint Pain_____
19. Artificial Joints_____
20. Kidney Disease/Stones_____
21. Hepatitis_____
22. Spinal Cord Injury_____
23. Traumatic Brain Injury_____
24. Fractures:
    a. Date_____
       Area_____
    b. Date_____
       Area_____
25. Polio/Muscle Disease_____
26. Thyroid Problems_____
27. Seizures_____
28. Chronic/Migraine headaches_____
29. TMJ Disorders_____
30. Chills/Fever/Sweats_____
31. Swelling of extremities_____
32. Osteoporosis_____
33. Depression_____
34. Fibromyalgia_____
35. Chronic Fatigue Syndrome_____
36. Lyme's Disease_____
37. Cancer/Tumors/Growths_____
38. Are you pregnant?_____
39. Gynecological Disorders_____
40. Bowel incontinence_____
41. Bladder incontinence_____
42. Diarrhea/Nausea/Vomiting_____
43. HIV/AIDS _____
44. Stroke _____
45. Unexplained weight loss > 10lbs in the last 30 days_____
46. Under 18 only:
    Immunizations current_____

Rate your pain from 0-10:

0 (none) 1 2 3 4 5 6 7 8 9 10 (unbearable)

Current Medications and dosages:

_____

_____

_____

Weight:_____ Height:_____

Recent MRI, X-RAY, or CAT SCAN?

Please list: _____

Allergies:

_____

_____

Surgery(s): Please include dates:

_____

_____

_____

What are your treatment goals?

_____

_____

MEDICARE PATIENTS: Are you currently receiving Home Health Care? YES or NO

Patient Signature _____ Date _____

Relationship if other than patient (parent or guardian if patient is a minor)_____

This information will be used as a guide to your treatment plan. If you need any medical follow-up, please contact your physician.

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Consent Form/Release of Information

Patient Name: _____

Consent to evaluation and treatment

I do hereby consent to the evaluation and treatment of Inspire Physical Therapy. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Release of information

I authorize Inspire Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio, or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my

(Doctor) _____, and (Insurance Company)_____,

and (other, if applicable)_____, _____
for communication and care coordination on my behalf. I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol, and psychiatric diagnosis.

Privacy Practices

I acknowledge receipt of the Inspire PT Notice of Privacy Practices, which I have received at the time of this admission or previously.

Assignment of Benefits

I request that payment of the Medicare/other insurance benefits be made on my behalf to Inspire PT for any services furnished to me by Inspire PT. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Financial Agreement

The undersigned agrees, whether signing as an agent or patient, that he/she individually obligates her or himself to pay for services rendered in accordance with the regular rates and terms of Inspire PT. Inspire PT will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

The undersigned certifies that he/she has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness Date

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Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

I understand that I may request in writing that Inspire PT would restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Inspire PT is not required to agree with my requested restrictions, but if Inspire PT does agree then it is bound to abide by such restrictions.

Patient Name _____

Relationship to Patient_____

Signature_____

Inspire PT has attempted to obtain the patient's signature in Acknowledgement of this notice of Privacy Practices, but was unable to do so as documented below:
Date:_____ Initials_____
Reason_____

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Cancellation/ No Show Policy

It is imperative that there be a consistency of treatment, as outlined by your physical therapist and physician, in order for your therapy to be of benefit and to achieve a successful outcome.

We will extend grace (not charge you) for the first missed visit. Thereafter, a $20 fee will be assessed for all missed visits unless you provide us with a 24 hour notification that you will be unable to keep your appointment. A voicemail after business hours is sufficient.

Please be advised that your health insurance will not reimburse you for this fee.

I have read and do understand that I will be personally responsible for the $20 fee if I miss a scheduled appointment without giving a 24 hour notice.

Patient (or Guardian) Signature: _____

Printed Patient Name: _____

Date: _____

FUNCTIONAL DRY NEEDLING® CONSENT AND REQUEST FOR PROCEDURE

Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on medical diagnosis to be effective.

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

Risks: The most serious risk with FDN is the 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.

Patient's Consent: I understand that no guarantee of assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Procedure: I, , authorize Inspire Physical Therapy to perform Functional Dry Needling® for my diagnosis of _____.

Please answer the following questions:

Are you pregnant? Yes No Are you immunocompromised? Yes No

Are you taking blood thinners? Yes No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

You have the right to withdraw consent for this procedure at any time before it is performed.

_____ _____ _____

Patient or Authorized Representative Date Time

_____ _____

Relationship to Patient (if other than patient) (Patient name printed)

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.

_____ _____ _____

Physical Therapist Date Time