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Appointment Date:_____ Time:_____
Therapist:_____
New / Returning

☐ Dry Creek ☐ Pearl Street ☐ Littleton

Today's Date: _____Initials:_____

Patient's Legal Name:_____ **Gender:** Male/Female **Patient DOB:**_____

Address: Street _____

City:_____ State: _____ Zip Code:_____

Patient Phone #:_____(H / C / W) **Secondary #:**_____(H / C / W)

Patient Email:_____

Prescription/Referral for PT?: _____ **Name of Referring Doctor/PA/NP:** _____

Diagnosis: _____

How did you hear about us? _____

Name of Primary Care Doctor:_____

Pain Evaluation:_____ **Balance Screen:**_____ **Running Evaluation:**_____

HEALTH INSURANCE

Primary Ins:	Ins Co Phone #:
Member ID:	Group #:
Secondary Ins:	Ins Co Phone #:
Member ID:	Group #:

AUTO / PERSONAL INJURY / WORK COMP

Ins Co:	Ins Co Phone #:
Claim #:	Date of Injury:
Adjuster's Name:	Phone #:

Consent for Treatment

I AUTHORIZE SPECIALIZED PT, INC. TO RENDER THE APPROPRIATE PHYSICAL THERAPY TREATMENT ACCORDING TO REASONABLE AND CUSTOMARY PHYSICAL THERAPY PRACTICE.

_____

Patient /Parent or Guardian (Please Print) **Date**

_____

Patient /Parent or Guardian's Signature **Date**

Emergency Contact:_____ **Relation:**_____ **Phone #:**_____

□ Faxed to Billing □ Emailed Paperwork □ Coming in Early

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Appointment Policy

Name _____ DOB / /

Last *First* *MI*

Specialized Physical Therapy is here to provide you with the best possible physical therapy with trained professionals. The following is some information that you need to be aware of so that we can continue to give you cutting edge care.

We realize that there are often circumstances in which you cannot control and we will try to work with you, so please let us know the reason for cancellation.

- **24-hour Cancellation/No Show policy –** We request a 24-hour appointment cancellation notice in order to give other patients the opportunity to receive treatment. Please give us as much notice as possible when cancelling an appointment. Also, our receptionists confirm your scheduled appointments while you are in treatment and via your preferred contact method in advance of your next appointment. Failure to show up for your scheduled appointment prevents us the opportunity of serving other patients.
    - You will be charged $75 for a cancelled scheduled appointment when notice given is less than 24 hours before appointment time or for failing to attend your scheduled appointment without 24-hour cancellation notification.
- **Late Arrival policy** – In the event you arrive late for your appointment, your treatment will end at its scheduled time in order not to keep the next person waiting.

Acknowledgement of Privacy Policy

As required by the HIPAA Privacy Regulations, all patients (or the patient's personal representative) who receive health care services from Specialized Physical Therapy, Inc. on or after April 14, 2003 must:

- receive and review the attached "Notice of Privacy Practices"; and
- review and sign the "Acknowledgement" Form (this page) and return it to our front desk for our records.

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Please note that the attached **Notice of Privacy Policies** is not a consent form that must be read in full by the patient and signed before treatment can be provided; rather, the Notice provides each patient with a summary description of
(1) how our office will use and disclose their medical information for legitimate business purposes, and
(2) how each patient can exercise their rights with regard to this medical information.

By signing below, I hereby acknowledge that I have read, understood and agree to abide by our Appointment Policy as described above and that I have received a current copy of the Notice of Privacy Notice.

Signature _____ Date / /

Must be signed by responsible party if patient is under 18 years of age

Printed Name _____

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Past Medical History *(please print clearly)*

Name _____ Date of Injury/Surgery ____/____/____
Last *First* *MI*

DOB ____/____/____ Could you be or are you pregnant? ☐Yes ☐No _____

Height ____feet ____ inches Weight _____ pounds

Have you had or currently have any of the following conditions?

Condition	Yes	No	Condition	Yes	No
Swelling in Ankles	☐	☐	Numbness/Tingling	☐	☐
Seizures / Epilepsy	☐	☐	Headaches	☐	☐
Metal in Body	☐	☐	Fever / Chill	☐	☐
Surgical Implant	☐	☐	Thyroid Problems	☐	☐
Recent Weight Loss/Gain	☐	☐	Head Injury/Concussion	☐	☐
Pacemaker	☐	☐	Hernia	☐	☐
Tuberculosis	☐	☐	Kidney/Bladder Problems	☐	☐
Recent Infection (in the last 3 months)	☐	☐	Previous Surgeries	☐	☐
Asthma	☐	☐	Depression	☐	☐
Shortness of Breath	☐	☐	Substance Abuse	☐	☐
Pain that keeps you awake at night	☐	☐	History of Smoking	☐	☐
Loss of Bladder or Bowel Control	☐	☐	Infection that did not respond to antibiotics (MRSA)	☐	☐
Urinary Leakage	☐	☐			
Have you had **two or more** falls within the past 12 months?	☐	☐	Have you had a fall **with injury** within the past 12 months?	☐	☐
Were these falls due to seizure or stroke?	☐	☐			

If you answered "yes" to any of the above, please explain below:

Have you ever been told you have:

Condition	Yes	No	Condition	Yes	No
Arthritis/Rheumatoid Arthritis	☐	☐	Vascular Disease	☐	☐
Osteoporosis/Osteopenia	☐	☐	Stroke	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐
Heart Attack	☐	☐	Cancer/Tumor	☐	☐
Neurological Disease (e.g. MS, Parkinson's, ALS)	☐	☐	Blood-borne Illness (e.g. HIV, Hepatitis)	☐	☐
Cardiac Disease	☐	☐			

Do you have allergies? ☐ No ☐ Yes (if Yes, please list them below)

Currently taking any medication? ☐ No ☐ Yes (if Yes, please list them below) and/or a Vitamin D supplement? ☐ No ☐ Yes

Include name, dosage, frequency and type (e.g. oral, injection):

What would you say is your current Health Status overall?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Patient Signature

Signature _____ Date ____/____/____

Printed Name

Must be signed by responsible party if patient is under 18 years of age.

Name

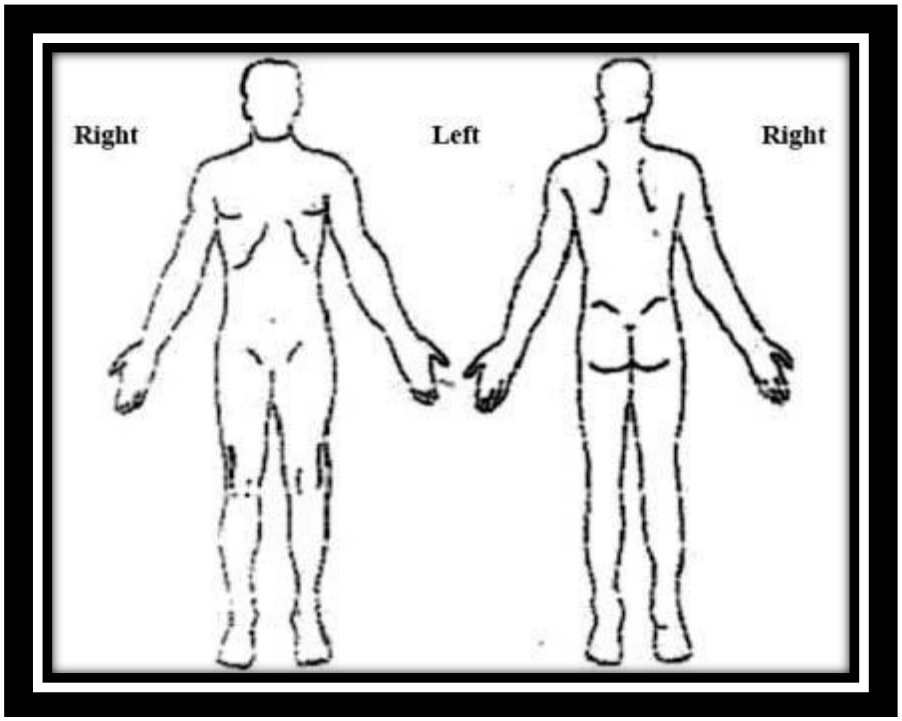
Last *First* *MI*

Please use the diagram below to indicate where you feel symptoms right now.

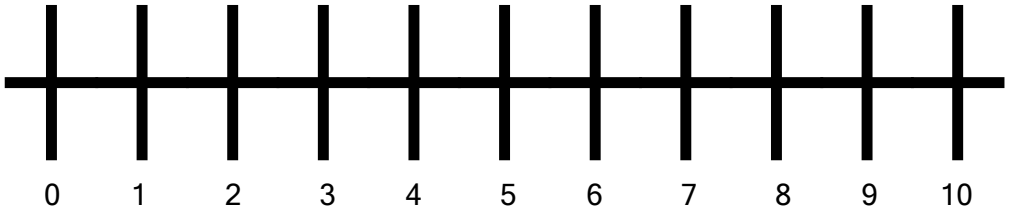
Use the following key to indicate the different types of symptoms:

KEY

Pins & Needles = 0000	Stabbing = ////
Deep Ache = zzzz	Burning = xxxx



Please circle on the scale below how you would rate your current pain level.
0= No Pain 10= Maximum Pain



For Clinician Use Only:

BMI: _____

TUG: _____

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Trigger Point Dry Needling Consent Form

Trigger point dry needling (TDN) 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 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.

RISKS OF THE PROCEDURE:

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 excessive bleeding (causing a bruise), infection and nerve injury. 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 TDN is unlikely.

INSURANCE BENEFITS:

Insurance benefits for TDN may be different from your physical therapy benefits. Any copay, co-insurance or deductible applied to TDN will be the responsibility of the patient.

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

_____

Please print your name

_____ _____

Signature Date

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Notice of Privacy Policies

Introduction

At Specialized Physical Therapy, Inc., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 1, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Specialized Physical Therapy, Inc., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Specialized Physical Therapy, Inc., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Specialized Physical Therapy, Inc. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Andy Fishering, VPO 720-493-1181.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights, Region 8
U.S. Department of Health and Human Services
Room 1426, Federal Office Building
1961 Stout Street
Denver, Colorado 80294

Examples of Disclosures for Treatment, Payment and Health Operations

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates:

There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory:

Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification:

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family:

Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research:

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors:

We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations:

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing:

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising:

We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA):

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation:

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health:

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.