Informed Consent

CONSENT FOR CARE AND TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for New Day Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

PRIVACY POLICY: I understand that New Day Physical Therapy will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

CONSENT FOR RELEASE OF MEDICAL RECORDS: I hereby authorize my physician to release any of my pertinent medical information to New Day Physical Therapy for use in the evaluation of my condition and the design of my individual treatment program.

CANCELLATION AND NO-SHOW POLICY: If you are unable to keep a scheduled appointment, please notify at least 24 hours in advance by cancelling via text message, voice call, or voice mail. If you miss your appointment without cancelling in advance, you may be dropped from future visits at the therapist's discretion.

FINANCIAL POLICY: I understand that New Day Physical Therapy is a fee-for-service physical therapy practice. I will pay for services with cash, check, credit card, or HSA/FSA at the time of service. I understand that if I want to submit the claim to my personal insurance carrier for reimbursement I will do so on my own behalf. New Day Physical Therapy will provide a receipt if requested.

Would you like a receipt to submit a claim to your insurance company? *YES* _____ *NO* _____

The above information has been explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient signature: _____ *Date:* _____

CONSENT FOR TREATMENT OF A MINOR: As a parent and/or legal guardian, I authorize New Day Physical Therapy to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian signature: _____ *Date:* _____

Dry Needling Consent Form

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. This will improve the function of the musculoskeletal system resulting in symptom reduction. No drugs are injected. Dry needling is a valuable treatment for musculoskeletal pain. However, like any treatment there are possible complications. While these complications are rare, they are real and must be considered prior to giving consent to treatment.

Risks of the procedure:

Though unlikely, the risks include, but are not limited to, post needling soreness, allergic reaction, vasodepressive syncope (feeling faint), nerve injury, vascular injury, penetration of a visceral organ, increased spasm, muscle edema, infection, and hematoma. Precautions are taken to avoid all of these.

The needles are very small and do not have a cutting edge, so the likelihood of any significant tissue trauma is unlikely. The risk of infection is minimal, as all OSHA Blood Borne Pathogens Standards will be abided by. Bruising is common and should not be a concern; however, if you are taking a blood thinner/anticoagulant or have an abnormal bleeding tendency, alert the PT to allow adjustment. Nerve injury is unlikely if you alert the PT immediately if you feel a paresthesia (a prickling or electric-like zing).

The most serious risk is accidental puncture of a lung (pneumothorax). If this were to occur, you may experience shortness of breath and it may require a chest x-ray and no further treatment. 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.

Soreness for 1-2 days can be a common response from the needling but does not occur with all people. Some individuals may experience an immediate achiness or a delayed soreness the next day. Use of heat or ice, light massage, and movement will help to decrease soreness.

- Are you currently pregnant? **YES** _____ **NO** _____
- Are you allergic to any metals, such as nickel or chromium? **YES** _____ **NO** _____
- Do you have any known disease or infection that can be transmitted or transferred through blood or bodily fluids? **YES** _____ **NO** _____

My signature certifies that I have read and understand this consent form, am aware of the risks and have been given the opportunity to ask questions and all of my questions have been answered. It also certifies that I have alerted the provider if I am taking medication to thin the blood, and that I do not have a bleeding disorder. I confirm that I have told if I have been taking other medicines, including aspirin or anti-inflammatories that may affect blood clotting. I confirm that I have disclosed any known disease or infection that can be transmitted through bodily fluids. I consent to notify if I become pregnant. The answers provided above are true and accurate to the best of my knowledge.

Signature _____ Date _____