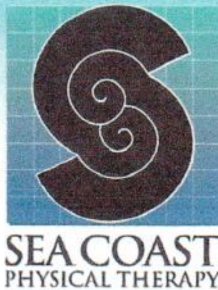

CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Sea Coast Physical Therapy, Inc.

I understand that I will be receiving an initial evaluation followed by one or several treatment sessions. These sessions may include one or more of the following: joint mobilization or manipulation; soft tissue work; manual therapy; electrical stimulation; ultrasound; heat/ice; mechanical and manual traction; passive/active range of motion; strengthening; stretching; exercise; and/or activity of daily living modification.

PATIENT or GUARDIAN signature/date: ______________________________

ASSIGNMENT OF BENEFITS AND INSURANCE PROCEEDS

I hereby authorize payment from my insurance company of medical benefits for services rendered to Sea Coast Physical Therapy, Inc. By an assignment of benefits. The completion of insurance forms and the assignment of insurance benefits do not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

SIGNATURE: ______________________________

RELEASE OF INFORMATION

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

SIGNATURE: ______________________________

RECEIPT OF PRIVACY ACT

I have received a copy of Sea Coast Physical Therapy notice of Privacy Practices and have had an opportunity to ask questions.

SIGNATURE: ______________________________

Patient Intake Form

Name____________________ SS#________________
Date of Birth________ Gender____ Marital Status____ Home Phone #________
Work Phone #________ Cell #________ Pager____ Email________
Home Address____________________
City____________ State________ Zip________

Employer____________________
Address____________________
____
City____________ State________ Zip________
Spouse's Name________________ Wk #____________
Emergency Contact________________ Phone #________

Whom May We Thank for Referring You to us?________________

Primary Care Physician________________ Phone #________

Please fill out If Spouse or Other is Primary Insured on Insurance Card

Their Name________________ Relationship to you ________
SS#____________ Date of Birth________ Phone#________

Please Fill Out if Workers Compensation Case

Name of WC Carrier________________ Phone#________
Address____________________
City____________ State________ Zip________
Claim #____________ Name of adjustor____________

Please Fill out if treatment is covered by Auto Insurance

Claim #____________ Name of adjustor____________
Phone #____________

Who Will Be Responsible For This Bill?

____

98 Quarter Horse Ln.
Hampstead, NC 28443
910-270-6488 Phone
910-270-6489 Fax

Past Medical History Form

Name:____Date:_____________Age:________

Occupation:____

Type of work: Example: Lifting, Bending, standing, sitting:________________________________

____

Past Medical History:

Do you have any previous history of: Yes or No

High Blood Pressure______________

Heart Conditions________________

Stroke(s)______________________

Diabetes______________________

Pacemaker_____________________

Seizures_______________________

Cancer________________________

Allergies_______________________

Other____

Have you been admitted to the hospital or undergone any surgical procedures in the past 5 years?_______If so please list:____

____

Have you received any physical therapy treatment in the past 5 years?___If yes, for what condition and was the treatment effective?____

____

Have you had any other previous medical problems or surgeries?_If yes, please list:__________

____

Did you receive any diagnostic tests (radiographs, MRI, CAT scan) for today's problem?__ If yes, please list:____

What medications are you currently taking?____

____

Are you pregnant?_______________

Name of your primary doctor:____

Name of your Orthopedic Doctor:____

Patient Signature____ **Date**______________

98 Quarter Horse Ln.
Hampstead, NC 28443
910-270-6488 Phone
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CANCELLATION AND NO SHOW POLICY

Sea Coast Physical Therapy is a private, one on one facility that is focused on patient care and outcomes. We have an extensive list of patients with multiple different diagnosis and "life" schedules. With that in mind, we spend a lot of time scheduling our weeks to maximize our time with our patients. If we have a short notice cancellation or a no show, the clinic and other patients suffer.

We require 24 hour notice of cancellation. We understand that life will throw obstacles at you, we all have families and jobs, but we are trying to maintain the integrity of a small clinic. Unless you have a death in the family or immediate medical emergency, we will charge $50 for an appointment not cancelled 24 hours ahead of scheduled time. A $50 charge will also apply to a No Show for scheduled appointments. The patient is responsible for this charge since insurance companies do not cover this.

We thank you for your understanding in this matter. Please sign below in acknowledgement of your acceptance of this condition of treatment.

Signature: ______________________________ Date: ________________

98 Quarter Horse Lane

Hampstead, NC 28443

(910) 270-6488 phone

(910) 270-6489 fax

DRY NEEDLING CONSENT AND INFORMATION FORM

What is Dry Needling? Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicines; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel, headaches, knee pain, shin splints, plantar fasciitis, or low back pain.

Is Dry Needling safe? Drowsiness, tiredness or dizziness occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe; however, serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in medical literature following needling; however, these are extremely rare events (1 in 200,000).

Is there anything your practitioner needs to know?

Have you ever fainted or experienced a seizure? Y/N Do you have a pacemaker or other implant? Y/N

Are you currently taking anticoagulants (blood thinners)? Y/N Are you currently taking antibiotics? Y/N

Do you have a damaged heart valve, metal prosthesis or other risk of infection? Y/N

Are you pregnant or actively trying? Y/N Do you suffer from metal allergies? Y/N

Are you a diabetic or do you suffer from impaired wound healing? Y/N

Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? Y/N

Have you eaten in the last 2 hours? Y/N

ONLY SINGLE USE, DISPOSABLE NEEDLES ARE USED AT THIS CLINIC.

STATEMENT OF CONSENT: I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I understand that I can refuse treatment at any time.

Signature: ______________________________ Date: ______________________

Printed Name: ____