MEDICATION LIST

Patient Name:_____

Use the chart below to list all **brand-name** and **generic prescription** medications you currently take. Please also include any **over-the-counter vitamins/supplements**. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the label in milligrams (mg). This is called the dose, or strength. The label on liquids and shots lists the dose. Please notify your PT of any changes in this list.

Medication/Vitamin Name	**Dose** (such as 2 mg, 1tsp)	**Method**	**How Often** (such as 3x/day)

The above medications have been discussed and reviewed with the patient by their PT at 1st Visit:

Physical Therapist Signature: _____ Date: _____

The above medications have been discussed and reviewed with the patient by their PT at re-evaluation or 10th visit:

Physical Therapist Signature: _____ Date: _____

Endurance Rehabilitation

Medicare Notice

Effective January 1, 2022 Medicare has changed the coverage of Physical Therapy/ Occupational Therapy services delivered in an outpatient setting. The Part B deductible is now $233 per calendar year. Medicare covers only certain procedures and therefore may not cover all of your healthcare costs.

- **Medicare pays 80% of the allowed amount and the beneficiary pays 20% up to $2,150.00, at which point your Physical Therapist/Occupational Therapist must justify medical necessity. Therapy services beyond $3,000 per calendar year are subject to medical review.**
- **Medicare will not pay for both home health care and outpatient therapy simultaneously.**

_____ I certify that I currently do not have home health care/have been discharged from any previous home health care treatments.

This form acknowledges that you are aware of the fact that you may be held financially responsible should Medicare not pay for your Physical/Occupational Therapy expenses. At some point in your treatment, you may be required to sign an ABN form. As you progress in your treatment, you, your therapist and your physician must prove medical necessity to Medicare in order to continue treatment.

_____ _____

Signature of Beneficiary **Date**

ENDURANCE REHABILITATION

Patient History

Name: _____ Preferred Name:_____

Date: _____Age: _____ Height: _____ Weight: _____

E-Mail Address: _____

How would you prefer your therapist to contact you? EMAIL PHONE

**All home exercise programs will be emailed*

Have you had physical therapy before? YES NO

How did you hear about Endurance Rehab?

- Internet
- Friend: _____
- Sport Club: _____
- Other: _____
- Insurance
- Physician: _____
- Store: _____

Did a physician refer you for this injury? YES NO If yes, who? : _____

If yes, when is your next follow-up appointment? _____

Main complaints/symptoms: _____

_____

Pain Level: At best: ____/10; At worst: ____/10 (0=no pain, 10= worst/maximal pain)

What intensifies the pain? _____

What alleviates your pain? _____

When did problem begin? _____

List functional limitations/difficulties (tasks during the day at home, work or recreationally)

1. _____ 2. _____ 3. _____

Was this an accident or work related injury? If so, date of accident/injury; describe what happened and where.

_____

_____

Have you had this or similar symptoms before? YES NO If yes, please describe:

_____

_____

Please list past surgeries, including minor:

Surgery: Date:

_____

_____

_____

ENDURANCE REHABILITATION

Patient name: _____ Date: _____

Please check any conditions/symptoms listed below that you have had in the past or are currently experiencing:

- Thyroid problems
- Hernia
- Cancer
- Headaches
- Migraines
- Neck stiffness
- Muscle spasms
- Muscle cramps
- Painful joints
- Fibromyalgia
- Osteoarthritis
- Rheumatoid arthritis
- Osteoporosis
- Osteopenia
- Multiple sclerosis
- Chills
- Weakness
- Dizziness
- Fatigue
- Fainting
- Seizures/Epilepsy
- Facial pain/numbness
- Vision deficits
- Ringing in ears
- Hearing loss
- Jaw pain
- Heat/cold intolerance
- Poor wound healing
- Diabetes
- Circulation problems
- Kidney problems
- UTI
- Asthma
- Emphysema
- Pain when breathing
- Shortness of breath
- Angina
- Heart attack
- High Blood pressure
- Heart Disease
- Pacemaker
- Abnormal Heart beat
- Stroke
- Anemia
- Anxiety
- Depression
- Loss of sleep
- Allergies

For any of the above conditions/symptoms that you marked, please explain:

_____

_____

_____

Please list any medications you are taking:

_____

_____

_____

Are you allergic to latex? YES NO
Are you taking a blood thinner? YES NO
Do you smoke? YES NO

<u>FEMALES</u>

Could you be or are you pregnant? YES NO

I attest that the information provided above is true:

Patient signature: _____ Date: _____

ENDURANCE REHABILITATION

Patient Rights & Responsibilities
Consent For Treatment
Medical Release

I, _____, hereby authorize Endurance Rehabilitation and/or its licensed medical professionals and such assistants to render any and all medical care deemed necessary and any additional care and supplies that are recommended.

Medical Record Release
This will authorize Endurance Rehabilitation to release any general, medical, as well as Psychiatric/Psychological, drug/alcohol, and HIV testing information from my health records, per patient's request.

Third Party Liability
Endurance Rehabilitation does not believe that a liability case against a third party is reason to delay payment of services. I agree that payment for services rendered is not contingent upon any settlement, judgment, or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered.

Assignment of Benefits
I authorize Endurance Rehabilitation to process claims related to my personal health or other insurance for covered services rendered to me. I also assign and authorize payment from said insurance carrier to be paid directly to Endurance Rehabilitation rendered on my behalf.

Circumstantial Risk
I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognize that I am free to seek other opinions relating to my health.

Financial Obligation
Endurance Rehabilitation requires that all co-pays, co-insurances and deductibles be paid at the time of service. Failure to maintain a current patient account may result in the placement of your account with an outside agency for Collection.

Finance Charge
All patients have a responsibility to keep their accounts current. A finance charge of 18% **per month** will be charged to all accounts 30 days delinquent.

I have reviewed and understand the Patient History, Patient Rights & Responsibilities, Consent For Treatment, Medical Release and HIPAA Privacy Notice. A copy of the aforementioned paperwork will be provided upon request.

Signature_____ Date_____

Endurance
Rehabilitation

Cancellation / No Show Policy

Dear Patient:

In an effort to provide all of our patients with the best care possible, it has become necessary to institute a policy regarding canceling your appointment or not showing up for your scheduled appointment. We will make every attempt to meet your busy schedule. If you are 20 minutes late for your appointment it may be necessary for us to re-schedule your appointment for a different time. If we are able to do that in the same day as your scheduled appointment you will not be charged. However if the appointment has to be moved to a different day due to scheduling conflicts you will be charged a $25 cancellation fee.

When canceling your appointment due to scheduling conflicts we ask that you please do so with 24 hours notice. In high traffic times we keep a waiting list of patients that would like to have your spot if it is available. If you are unable to cancel your appointment with 24 hours notice, you will be charged a $25 cancellation fee.

For those unfortunate times when you are unable to make your appointment and fail to call us, you will also be charged a $25 no show fee.

Thank you in advance for your effort to help us provide quality care to all of our patients by being as prompt as possible.

Sincerely,

Nate Koch
Owner

Patient Signature **Date**

Appointment Reminder Option

Complete this form and sign below to give your permission for Endurance Rehabilitation, LLC to provide automatic appointment reminder service by email.

Please select <u>ONE</u> option -

☐ **YES:** Endurance Rehabilitation, LLC may send email messages to confirm my upcoming appointments to:

_____

☐ **NO**: I would not like reminders from Endurance Rehabilitation, LLC.

Name of Patient _____

Signature _____

Date _____

DRY NEEDLING CONSENT & 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 Medicine; 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 syndrome, 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 in 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 a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, 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 the medical literature following needling: however, these are extremely rare events (1 in 200,000).

Is there anything your practitioner needs to know?

1. Have you ever fainted or experienced a seizure? YES / NO
2. Do you have a pacemaker or any other electrical implant? YES / NO
3. Are you currently taking anticoagulants (blood thinners: e.g. Aspirin, Warfarin, or Coumadin)? YES / NO
4. Are you currently taking antibiotics for an infection? YES / NO
5. Do you have a damaged heart valve, metal prosthesis, or other risk of infection? YES / NO
6. Are you pregnant or actively trying for a pregnancy? YES / NO

7. Do you suffer from metal allergies? YES / NO
8. Are you a diabetic or do you suffer from impaired wound healing? YES / NO
9. Do you have hepatitis B, C, HIV, or any other infectious disease? YES / NO
10. Have you eaten in the last two hours? YES / NO

Single-use, disposable needles are used in this clinic.

Endurance Rehabilitation requests that payment be collected at each visit. Insurance does not pay for this service.

- **Dry needling with Physical Therapy - $25**
- **Dry needling without therapy - $65**
- **Dry needling without therapy – 10/$550**

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.

Printed Name: _____

Signature: _____ Date: _____

****YOU DO HAVE THE OPTION TO DECLINE OR REQUEST MORE INFORMATION. PLEASE CHECK THE BOX BELOW IF YOU WOULD PREFER ONE OF THESE OPTIONS****

☐ **DECLINE DRY NEEDLING (You can change your mind at any time)**

☐ **PLEASE HAVE THE THERAPIST GIVE ME MORE INFORMATION ABOUT DRY NEEDLING**

Initials _____

Special Consent to FDA Approved "Erchonia Low-Level Laser" for demonstration laser application.

Patient's Name: _____ Date: _____

Clinic Name: _____Endurance Rehabilitation_____

The Erchonia Low Level Lasers offer a new clinically proven treatment option that is safe, effective and cleared by the FDA for the treatment of:

- Chronic Neck Pain
- Chronic Shoulder Pain
- Chronic Low Back Pain
- Post-Operative Pain
- Heel Pain related to Plantar Fasciitis

Low Level laser therapy is a painless, sterile, non-invasive, drug free modality that is used for a variety of conditions such as acute and chronic pain, body contouring, acne and appearance of cellulite.

Endurance Rehabilitation requests that payment be collected at each visit.
Insurance does not pay for this service.

Single laser treatment - $30 / session

Discounted package - $250 for 10 sessions

Patient's Acknowledgement

I acknowledge that I am not pregnant: _____

I acknowledge that I do not have a pacemaker: _____

I acknowledge that I would like a laser demonstration today (if therapist recommends): _____

I acknowledge that I have read (or have had read to me) and fully understand the above consent, the explanations referred to above were complete and all blanks, if any, were filled in before I affixed my signature.

Patient or Patient's Representative Signature:_____ **Date**:_____

****YOU DO HAVE THE OPTION TO DECLINE OR REQUEST MORE INFORMATION. PLEASE CHECK THE BOX BELOW IF YOU WOULD PREFER ONE OF THESE OPTIONS****

☐ **DECLINE LASER (You can change your mind at any time)**

☐ **PLEASE HAVE THE THERAPIST GIVE ME MORE INFORMATION ABOUT LASER TREAMENT**

Initials _____

SERVICES we provide NOT covered by insurance:

To be cost transparent, we are providing a list of services that are typically NOT covered by insurance. If you have any questions or concerns regarding coverage please do not hesitate to ask our front office or Practice Manager.

ASTYM only treatment = $65

Dry Needling with Therapy = $25

Dry Needling without Therapy = $65/session

Taping Session = $10

Wellness = $65 - $85 /month

Recovery boots only= Punch Card $90 for 10 or $10/session

Iontophoresis = $20

Traction ONLY = $25

Laser treatment - $30 per session or $250 for 10 sessions

Supplies

Electrical Stim Pads = $5 (MOST COMMON)

Foam Roller = $12 - $35

Tape Roll = $20

Therabands = $7

Pulleys = $10

Please initial here that you understand that you will be charged for any of the above referenced services or supplies only if you need or request them!

PATIENT INITIALS HERE: _____

Print Name _____ Date _____

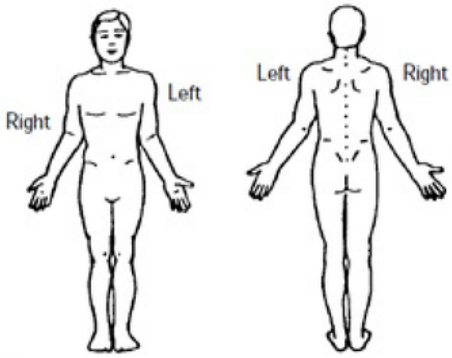
Date: ____/____/____ Time: _____

Name: _____ _____ _____
Last First Middle intial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on **average**.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No pain — Completely interferes

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10 20 30 40 50 60 70 80 90 100%
No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
No pain — Completely interferes

Endurance REHAB

Telehealth Patient Consent/Decline Form

Patient Name: _____

Patient Address: _____

Date of Birth: ___/___/___

Purpose: The purpose of this form is to obtain your consent to participate in a Telehealth Consultation in connection with the following procedure(s) and/or service(s) :

_____

1. Nature of Telehealth Consult: During the telehealth consultation:
    a. Details of your medical history, examinations, x-rays, and tests will be discussed with other health care professionals through the use of interactive video, audio and telecommunication technology.
    b. A physical examination may take place.
    c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
    d. Video, audio and/or photo recording may be taken of you during the procedure(s) or service(s).
2. Medical Information & Records: All existing laws regarding your success to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information for this telehealth interaction to any other parties or entities shall not occur without your consent.
3. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth consultation, and all existing confidentially protections under state and federal law apply to information disclosed during this telehealth consultation.
4. Rights: You may withhold or withdraw your consent to the telehealth consultation at any time without affecting your right to future care or treatment.
5. Disputes:
6. Risks, Consequences & Benefits: You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care provider has discussed with you the information provided above.

I agree to participate in Endurance Rehab Telehealth Health Care for the procedure(s) and/or service(s) above.

I understand that my insurance may NOT pay for this visit. If they do not pay, I agree to pay $65 per Telehealth visit with my Physical Therapist.

Signature: _____ Date: ___/____/_____ Time: _____

If signed by someone other than the patient, indicate the relationship: _____

Witness Signature: _____ Witness Name in Print: _____

Date___/____/____ Time: _____

To Decline Service: _____ Date___/____/____ Time: _____