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

FEMALES
Could you be or are you pregnant? YES NO

I attest that the information provided above is true:

Patient signature: ____________________________________ Date: _____________________

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.

Cancellation/No Show Policy
When canceling your appointment due to scheduling conflicts we ask that you please do so by 4:00 the day prior. 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 by 4:00 pm the prior day, or if you are unable to make your appointment and do call us, you will be charged a $25 fee.

I have reviewed and understand the Patient History, Patient Rights & Responsibilities, Consent For Treatment, Financial Responsibility, Medical Release, Cancellation/No Show Policy, and HIPAA Privacy Notice. A copy of the aforementioned paperwork will be provided upon request.

Print Patient's Name: _____

_____ _____

Patient or Parent/Guardian Signature **Date**

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 for 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: _____ AM PM

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

Witness Signature: _____ Witness Name in Print:
_____

Date___/____/____ Time: _____ AM PM

- **CHECK THIS BOX IF YOU CHOOSE TO REFUSE TELEHEALTH SERVICES - Initials _____**

Appointment E-mail 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 ONE option – <u>Text option is NOT available!</u>

▫ **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 _____

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 _____

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 _____

CREDIT CARD PAYMENT AUTHORIZATION

The below listed Merchant's card payment software allows for the secure storage of credit card information, through tokenization, for future payments associated with Merchant's health care practice. You authorize charges to your credit card by Endurance Rehab as payment for all products, services, fees and charges under your account. A receipt for each payment will be provided to you via email and the charge will appear on your credit card statement. Should Endurance Rehab or cardholder change the terms of this agreement, including the use of the stored card data or its tokenization practices, below are the contact points.

****YOU ONLY NEED TO FILL OUT THIS FORM IF YOU WOULD LIKE TO KEEP A CARD ON FILE FOR SERVICES PROVIDED. IF YOU PREFER TO BRING YOUR CARD TO EVERY VISIT, YOU MAY SKIP THIS FORM****

Merchant Information

Address: 9376 E Bahia Drive #103 Scottsdale, AZ 85260
Phone #: 480-556-8406

Customer Billing and Contact Information

Billing Address: _____

Phone #: _____

Email: _____

Card Details

- Visa
- Mastercard
- Discover

Patient Name: _____

Cardholder Name: _____

Card Number Ending in (**LAST 4 DIGITS ONLY**): _____/_____/_____/_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Endurance Rehab in writing of any changes in my account information or termination of this authorization. I acknowledge that the origination of credit card transactions to my account must comply with the provisions of U.S. law and will be used to pay any overdue outstanding invoices for my account. I certify that I am an authorized user of this credit card.

SIGNATURE _____ Date _____

(Cardholder Signature)

ONLY FILL OUT THIS FORM IF YOU FILLED OUT THE PREVIOUS FORM. FEEL FREE TO SKIP IF YOU PLAN TO BRING YOUR CARD EVERY VISIT.

Card Number

_____

Expiration Date

_____

For security reasons, we do not keep full credit cards written anywhere in our office. We only need this information to enter in our secure terminal. Once the full card has been entered, we will shred this form