

OFFICE POLICIES AND PROCEDURES

Thank you for choosing Functionize Health & Physical Therapy for your Physical Therapy needs.

I acknowledge that a copy of the notice of privacy is provided to me and I have read and understood or declined to read the Notice of Privacy Practices. I understand that these privacy practices will be followed by Functionize Health & Physical Therapy to ensure the privacy of my personal health information. I understand that this will be placed in my patient chart and maintained for 10 years.

PAYMENT/BILLING POLICIES

Functionize Health and Physical Therapy is a fee-for-service clinic. This means that payment is due at the time services are rendered. We will not bill your insurance company. We can provide receipts with diagnosis and treatment codes which you may use to submit to your insurance company to get reimbursed. If further documentation is requested, these will be provided. We accept cash, personal checks, and credit cards.

Given you will be paying at the time of services, if your insurance company reimburses our clinic, these monies will be returned to them and a new check must be issued to you personally.

Supplies and additional items are an added cost.

PRIVACY POLICY

I understand that Functionize Health and 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 the treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I also grant permission for this practice and its affiliates to obtain information from my physician and other medical professionals as it relates to my treatment.

CONSENT TO TREATMENT

Functionize Health and Physical Therapy is a hands-on Physical Therapy and Wellness clinic. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of electrical stimulation, cold laser, traction, deep tissue massage, therapeutic exercise programs, therapeutic activities, gait training, neuromuscular re-education, myofascial techniques, bone and soft tissue manipulation, as well as other treatment modalities may be used. During your treatment, symptoms may change or move to other parts of the body. This is not unusual and is rarely a concern, however, please ask if you have any questions or concerns. The number of treatments needed and recovery time can vary due to age of injury, number of times injured, number of surgeries, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at *Functionize* Health and Physical Therapy. I am aware of my diagnosis and voluntarily consent to treatment at this practice. I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

CANCELLATION POLICY

As a courtesy to others, our Therapists, and other patients trying to get scheduled, we require a **48-hour notice** for cancellations. This allows others on our waiting list to be seen. Only emergencies or illnesses are excusable. A **\$75 fee** will be billed upon violation of this policy.

I have read and completely understand the above written statements

Signature: _____

Date: _____

Print Name: _____

FOR CLIENTS WITH MEDICARE

Medicare will not pay for physical therapy services rendered at Functionize Health and Physical Therapy. There may be a good reason your doctor, healthcare provider, or fitness professional has recommended it. At this time, Medicare will not pay for our services as we are not a Participating Provider with Medicare or any other insurance company. We only agree to work with Medicare clients for fitness, prevention, and wellness goals (which are not covered services under Medicare). You will not be able to submit for reimbursement as our services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare requires. Signing below means that you have received and understand this notice.

I, _____, request full privacy for the services provided by Functionize Health & Physical Therapy and its affiliates and refuse to authorize the submission of any claim (s) by Functionize Health & Physical Therapy. I understand that I am responsible for any out of pocket expense for the services rendered to me by Functionize Health & Physical Therapy and its affiliates and agree not to submit any and all claims independently to Medicare for the services rendered by Functionize Health & Physical Therapy.

I acknowledge that this is my right to receive services with full privacy as described on page 5628 of the Federal Register Vol. 78, No. 17 issued on January 25, 2013 from the Department of Health and Human Services.

I fully understand that I am responsible for payment at the time of services and will not try to collect reimbursement from Medicare or my supplemental insurance.

I have read and completely understand the above written statements

Signature: _____

Date: _____

Print Name: _____

DRY NEEDLING CONSENT & INFORMATION FORM

What is Dry Needling?

Dry needling is a form of therapy in which fine needles are inserted in 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, scientific-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 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, 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, hepatitis C, HIV, or any other infectious disease? | YES/ NO |
| 10. Have you eaten in the last two hours? | YES/ NO |
| 11. Do you become faint or lightheaded with the sight or thought of needles? | YES/ NO |
| 12. Have you had a breast augmentation (“implants”)? | YES/ NO |

Single-use, disposable needles are used in this clinic

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: _____

Print Name: _____