Patient Intake Form

Patient Information:

Last Name: _____ First Name: _____ Sex: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Work#: _____ Home#: _____

Email: _____ Mobile#: _____

Marital Status: (of parent/guardian) Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

Employer's Name: _____ Occupation: _____

Physician's Name: _____ Diagnosis: _____

Injury: Sport related? _____ Allergies or Medical Precautions: _____

Emergency Contact: _____ Phone#: _____

Other Members of Your Healthcare Team

(attach additional pages if needed)

Practitioner name: _____ Practice name: _____

City/state of office: _____ Date of last visit: _____

« ☐ » Check here if you do not want us to share your treatment information with this person.

Perfect 10.0 Physical Therapy, PLC
Phone: 571-252-9131 | Email: egreene@perfect10pt.org
Fax: 571-410-2230 | Website: www.perfect10pt.org

Patient Intake Form

Payment Policies:

I hereby understand that full payment is due 24 hours prior to my scheduled appointment time as a confirmation of appointment. Payment received later than 24 hours is considered a "late fee" and will be subject to a "late fee" charge, as well as a loss of my scheduled appointment slot.
I hereby accept responsibility for the cost of this examination or treatment.
I hereby understand and agree to accept responsibility of the cancellation policy of this office: Giving 24 hour notice to cancel: If I am unable to comply but reschedule the appointment before and within the end of the week, no charge will be made. Otherwise, a fee equal to the total cost of the scheduled service will be charged for the missed appointment.

Please note that this fee is your responsibility- Insurance companies do not reimburse for missed appointments.

Forms of payment we accept: Cash, Check, or Square.
Please make checks payable to "Perfect 10.0 Physical Therapy, PLC."

Additional Policies:

My Communication With You
By providing the above information, or by initiating communication with me by email or text message, you authorize me to call, leave voicemails, and send text messages using that information. I may use this information for appointment reminders, billing and invoicing updates, and treatment questions. You further understand and agree that communicating with me by unencrypted emails and text messages may not be secure. This also means that your protected health information ("PHI") may be transmitted in this way, including information about your appointments, diagnosis, progress, and other individually identifiable information. If you choose to communicate via text or email, please limit the content to general information (such as scheduling or asking for a time to talk via phone). Please be aware of privacy risks when using electronic means of communication.

Mandated Reporting
• **Child Abuse.** Virginia law requires me to report all child abuse to the Virginia Department of Child Protective Services (CPS). I must call CPS if I have reasonable cause to believe that a child who is known to me in my professional capacity may be abused or neglected. It is my policy to notify you prior to contacting CPS if, in my professional judgment, it is reasonable to do so.
• **Elder Abuse.** Virginia law requires me to report the abuse of elders or vulnerable adults to the Virginia Department of Adult Protective Services. This may include physical, sexual, financial, or psychological abuse, neglect, or exploitation.

Patient's signature: _____

Date Signed: _____

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Perfect 10.0 Physical Therapy, PLC

Patient Questionnaire / History

Name: _____ Date of Birth: _____

☐ Right or ☐ Left handed

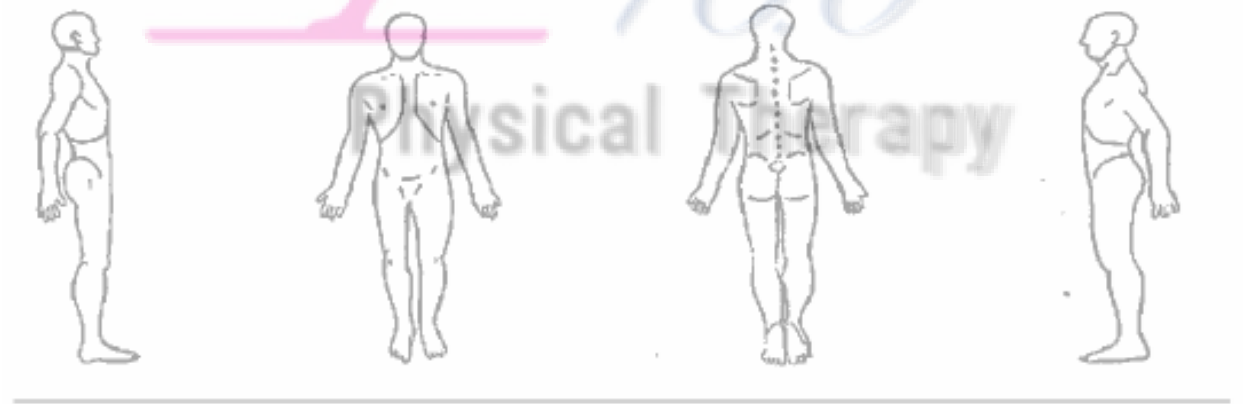
Rate your chief complaint in order of severity from worst (5) to least (1)

Pain ☐ Decreased Motion ☐ Swelling/ edema ☐ Stiffness ☐ Loss of function ☐

Where is your problem? Indicate on the body chart. Pain xxx: Numbness ooo: Tingling zzz:

Indicate the nature of your pain and symptoms:

Sharp	☐	Superficial	☐
Dull	☐	Tingling	☐
Piercing	☐	Numbness	☐
Shooting	☐	Intermittent	☐
Aching	☐	Burning	☐
Deep	☐	Stabbing	☐



When and how did this problem begin? _____

What makes your symptoms/ pain worse? _____

What makes your symptoms/ pain lessen? _____

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Patient Questionnaire / History

Rate your pain on a visual scale (0-10):
0 = No Pain, 10 = Excruciating Pain

- ☐ Worst it has been
- ☐ Past 2 to 4 weeks
- ☐ Past 24 hours
- ☐ At this moment

Are your symptoms worse in the:

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Inconsistent

Are your symptoms:

- ☐ Improving
- ☐ Worse
- ☐ Stable

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Perfect 10.0 Physical Therapy, PLC

Medical History

Has this problem affected your daily life or routine? Briefly describe in what ways. _____

_____

_____

Have you had past similar episodes of this current problem? If yes, were you treated with; (circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self-medicated (Advil), ignored it, other, Did they help to alleviate your symptoms? _____

_____

_____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC)
If yes, do you know the results? _____

_____

_____

_____

Please answer the following questions:	Yes	No
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (cane foot orthotics)		

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Medical History

Please answer the following questions (cont'd):

	Yes	No
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

Any other illness, past injuries I should be aware of?

Past surgeries: ☐ Yes, ☐ No, give brief details: _____

_____

List the medications you are currently taking (over the counter/prescription): _____

_____

_____

_____

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Social History

Are you presently working?

☐ Yes, ☐ No, since: _____

Physical/Emotional demands of present occupation? (High, moderate, minimal) Explain:

_____

_____

Overall activity level:

☐ Sedentary,
☐ Light,
☐ Moderate,
☐ Heavy,
☐ Very heavy

Sports and Exercise (Type, Frequency, Duration): _____

_____

_____

_____

Use of Tobacco:

☐ Yes
☐ No

Use of Alcohol:

☐ Yes
☐ No

Social History

Family Medical History:

Does anyone in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer? _____

_____

_____

Please list three (3) goals of Physical Therapy and time frames:

#	Goal	Time Frame
1)		
2)		
3)		

Who can we thank for this referral? _____

_____

Thank You for Your Patience and Valuable Time!!!

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Virginia Direct Access Patient Attestation

Virginians may receive physical therapy from a licensed physical therapist without first needing a prescription or referral from a physician or other healthcare provider. This is called "direct access." Patients are encouraged to contact their employer's healthcare plan to confirm participation and whether a referral is still required.

Although most insurance carriers allow Direct Access, there are a few that may still require a physician's referral before they will pay for services.

Patients are encouraged to contact their insurance carrier to confirm coverage. Any balances not covered by your insurance will be your responsibility.

Accordingly, you understand that that (i) your treatment may not be covered by your healthcare plan or insurer if you do not first obtain a physical therapy referral ("qualifying referral") and that your treatment may be a covered expense if rendered pursuant to a qualifying referral; and (ii) you are solely responsible for contacting your insurer to determine whether it covers treatment that is rendered without a qualifying referral.

Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____

_____ _____

Street address, City, ST, ZIP Code Primary Phone Number

Reason why you are seeking physical therapy care: _____

_____

_____

Patient Attestation

Please initial each of the following:

	I AM NOT under the care of a licensed health practitioner for the symptoms listed on this form and I wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.). I understand that I will be required to provide a practitioner of record and that the practitioner identified on this form will be provided a copy of the initial evaluation by the physical therapist within 14 days.
	I understand that a physical therapy diagnosis is not the same as a medical diagnosis by a physician or based on radiological imaging and that such services might not be covered by my health plan or insurer.
	I AM under the care of a licensed health practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)
	I understand that I cannot be evaluated or treated for the same condition previously treated within the immediately preceding 60-days

Virginia Direct Access Patient Attestation

Patient Attestation (Cont'd)

Please initial each of the following:

☐ I hereby consent to the release of my personal health information and treatment records to the Practitioner of Record listed below.

Practitioner of Record
(required for treatment)

Practitioner Name: _____ Office Name: _____

Office Phone Number: _____

Patient Signature _____ Date _____

Parent/Guardian Signature _____

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Notice of Privacy Practices

This notice describes how Perfect 10.0 Physical Therapy, PLC may use and disclose your medical information. It also explains how you can get access to this information. Please review it carefully.

Privacy Practices in Summary

Patient Rights. *You have the right to:*

Get a copy of your paper or electronic medical record.	Correct your paper or electronic medical record.
File a complaint if you believe your privacy rights have been violated.	Ask us to limit the information we share about you.
Get a list of those with whom we've shared your information.	Get a copy of this Notice of Privacy Practices.
Request that we use only confidential communication methods with you.	Choose someone to act on your behalf.

Patient Choices. *You have choices about how we use your information:*

If we tell your family or friends about your conditions.	If we provide disaster relief services.
If we sell your information.	If we market our services.

Our Uses and Disclosures of Your Information. *We may use your information when we conduct these activities:*

Help with public health and safety issues.	Bill you or a third party for our services.
Comply with the law.	Conduct research.
Respond to lawsuits and legal actions.	Address law enforcement or other government requests.
Treat you.	Perform privacy reviews and audits.

Privacy Practices in Detail

Detailed Patient Rights. *You have certain rights. This section explains some of your rights and some of our related responsibilities.*

You may: Obtain an electronic or paper copy of your medical record.	You may ask us to see or obtain an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. Under most circumstances, we will provide you with a copy or a summary of your health information within 30 days of your request. You may also request we send your medical record or other information to another person or entity. We may charge a reasonable, cost-based fee. Please note, you don't have the right to access information that does not directly relate to you. This may include, but is not limited to, business planning records, quality assessment records, or management records used for business decisions generally rather than to make decisions about you as an individual.

Notice of Privacy Practices

Detailed Patient Rights (Cont'd):

You may: Ask us to correct the information in your medical record.	You may ask us to correct health information in your record that you believe is incorrect or incomplete. Ask us how to do this. If we deny your request, we will provide you a written explanation for that denial within 60 days.
You may: Request confidential communications from us.	You may ask us to contact you in a specific way (e.g., cell phone only), or to send mail to a different address (e.g., a friend's home). We will comply with all reasonable requests.
You may: Ask us to limit what information we use or share.	You may ask us to refrain from using or sharing certain health information for your treatment, in our operations, or to obtain payment for our services. We are not required to comply with your request, and we may decline your request if we reasonably believe that it would affect your care. If we do accept your request, then we must comply with all agreed restrictions, except for the purposes of treating you in a medical emergency. If you pay for our services or a healthcare item in full out- of-pocket, you may ask that we not share that information for the purpose of securing payment or sharing our healthcare operations with your health insurer. We will agree to this request unless a law requires otherwise.
You may: Request a copy of this Notice of Privacy Practices.	You may request a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
You may: Request a list of those with whom we have shared information about you.	You may request a list (called an accounting) of the times that we have shared your health information for the six years prior to the date of your request. The accounting will include the recipient and the reason your information was shared. We will include all disclosures except for those relating to treatment, payment, healthcare operations, and certain other disclosures (e.g., those you asked us to make). We will provide you with one accounting per year at no cost, but we will charge a reasonable, cost-based fee if you request another within 12 months.
You may: Choose someone to act on your behalf.	If you have given someone your medical power of attorney, or if someone is your legal guardian, that person may exercise your rights and make choices about your health information. We will verify that this person has this authority and can act for you before we take any action.

Notice of Privacy Practices

Detailed Patient Rights (Cont'd):

You may: File a complaint if you feel your privacy rights are violated.	You may complain to our Privacy Officer if you believe we violated your rights. You may also file a complaint by sending a letter to: U.S. Dept. of Health and Human Services Office for Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 You may also call (877) 696-6675 or visit www.hhs.gov. We will not retaliate against you for filing a complaint.

Detailed Patient Choices. *You have some choices about how we use and disclose your information. If you have a clear preference for how we share your information in the situations described below, please discuss that with us so we may respect your wishes.*

In these situations, you have a right and a choice to instruct us as to how you'd like us to:

- Share information with your family or others involved in your care.
- Share information as we respond to a disaster relief situation.

If you cannot tell us your preference (e.g., if you are incapacitated), we may share your information as we believe is in your best interest. We may share your information when it is necessary to lessen a serious and imminent threat to health or safety. You may also designate someone to tell us your preference on your behalf.

In other situations, however, we will never share your information unless you provide us with your written permission:

- When we seek to use your information for our marketing purposes.
- When we seek to sell your information.
- When we seek to share any patient notes or HIV-related information from your record.

Detailed Uses and Disclosures by our Practice. *The most common ways we use or share your health information include when we:*

Treat you.	We can use your health information and share it with other professionals who are treating you. This may include the sharing of information to covered entities that are not part of your direct treatment team (Students).

Notice of Privacy Practices

Operate our practice.	We can use and share your health information to run our practice, improve your care, and contact you.
Bill for our services.	We can use and share your health information to bill and obtain payment from health plans or other entities.

The less common ways we use or share your health information include when we:

Report suspected abuse, neglect, or domestic violence.	Report adverse medication reactions.
Assist with public health and safety issues.	Prevent or reduce a serious threat to anyone's health or safety.
Conduct research.	Prevent disease.
Support government functions such as military, national security, and presidential protective services.	Contribute to the public good or assist with public health and research.
Respond to workers 'compensation claims.	Support health oversight agencies' activities as authorized by law.
Comply with state or federal laws.	Respond to law enforcement requests.
Assist with product recalls.	Respond to lawsuits and legal actions.
Respond to court or administrative agency orders or subpoenas.	Demonstrate to HHS we are compliant with federal privacy laws.

We must comply with several conditions in the law before we can share your information for these purposes. For more information, see: hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Detailed Practice Responsibilities:
The law requires us to maintain the privacy and security of your protected health information. This includes maintaining reasonable and appropriate administrative, technical, and physical safeguards to protect the unauthorized use or disclosure of your protected information. We will alert you promptly if a breach occurs that may have compromised the privacy or security of your information. Additionally, we will mitigate, to the extent practicable, any harmful effect we learn was caused by a breach of privacy. We must comply with the duties and privacy practices described in this notice, and we must offer you a

Notice of Privacy Practices

copy of this document. We will not use or share your information, other than as described here, without your express written permission. If you authorize a use or disclosure of your information, you may revoke that authorization in writing at any time. *For more information, visit HHS' website at hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.*

About This Notice:

- This notice is effective May 2022.
- Our Chief Privacy Officer is Dr. Ezara Greene.
- You can contact our Chief Privacy Officer to file a complaint if you feel your rights have been violated or to ask further questions about your privacy rights.
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

I, the undersigned, have received, read, and understand this Notice of Privacy Practices concerning the use and disclosure of my protected medical information. I understand you have the right to amend this notice.

Patient Name or Legal Guardian _____

Signature: _____ Date: _____

Perfect 10.0 Physical Therapy, PLC
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Fax: 571-410-2230 | Website: www.perfect10pt.org

Written Acknowledgement of Receipt of Notice of Privacy Practice

Patient: _____

I, _____ hereby acknowledge that I have received a copy of The Notice of Privacy Practices.

Signature: _____

Relationship to Patient (if patient is a minor): _____

Date: _____

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Photo Release Form

Important Information for Parents & Patients
As part of delivering high-quality physical therapy care for our patients Dr. Greene and Dr. Rafaelano may utilize photographs and/or video recordings during sessions. These images help ensure accurate assessment, effective treatment planning, and measurable progress tracking.

This form is divided into **two separate sections**:

- **Part A (Required)**: Clinical documentation and internal professional education
- **Part B (Optional)**: Marketing, social media, and public-facing use

Your decision regarding **Part B** will not affect your child's care.

PART A – REQUIRED CONSENT FOR CLINICAL CARE (Virginia-Compliant)

In accordance with the **Virginia Board of Physical Therapy**, state licensure requirements, and HIPAA regulations, I understand and agree that photographs and/or videos of my child may be taken **as a necessary component of physical therapy evaluation and treatment.**

These images may be used for:

- Clinical examination, movement analysis, and treatment planning
- Ongoing progress tracking and comparison throughout the plan of care
- Documentation within the medical record as Protected Health Information (PHI)
- **Internal, de-identified professional education and training**, including case review, clinician education, and professional presentations

All images and videos collected under this section will:

- Be maintained securely in compliance with HIPAA and Virginia state regulations
- Be accessed only by authorized healthcare professionals
- Not be used for advertising, marketing, or public-facing purposes

Consent for Part A is required to initiate and continue physical therapy services, as visual documentation is integral to skilled assessment, treatment progression, and professional accountability.

☐ I CONSENT to Part A (Required)

PART B – OPTIONAL CONSENT FOR MARKETING & PUBLIC USE

I voluntarily grant permission for Perfect 10.0 Physical Therapy, PLC to use photographs and/or videos of my child for **public-facing and promotional purposes**, which may include:

- Practice website content
- Social media platforms (e.g., Instagram, Facebook, TikTok, website)
- Educational or promotional materials
- Community or professional outreach

I understand that:

- Consent for Part B is entirely voluntary
- Declining Part B will not affect evaluation, treatment, or access to services

Photo Release Form

- Images used publicly may include identifiable features unless otherwise specified

☐ YES, I consent to Part B (Optional marketing & social media use)
☐ NO, I do NOT consent to Part B

OPTIONAL MARKETING REFUSAL ACKNOWLEDGEMENT
I acknowledge that I have **declined consent** for the use of my child's photographs and/or videos for marketing, social media, or other public-facing purposes. I understand that:

- My decision does not impact my child's physical therapy care
- Clinical photo/video use for documentation and treatment (Part A) may still occur
- This refusal will be honored unless I provide written authorization in the future

Initials (Parent/Guardian): _____ **Date**: _____

Patient & Parent/Guardian Information
Child's Name: _____
Parent/Guardian Name: _____
Signature: _____
Date: _____
Phone Number: _____

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Authorization for Use or Disclosure of Protected Health Information

Name of Patient: _____

Date of Birth: _____ SSN: _____ Medical Record #: _____

Daytime Phone #: _____ Evening Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Perfect 10.0 Physical Therapy, PLC to use or disclose my protected health information as indicated below to:

Name: _____

Daytime Phone #: _____ Evening Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I understand that this may include HIV-related information, and by signing this form, I am specifically authorizing the release of this information.

Signature of Patient or Legal Guardian: _____

Date: _____

Information to be released from my record:

From & To Dates: _____ History and Physical Exams: _____

Lab Report: _____ X-Ray Report: _____

Consultant Report: _____ Other: _____

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Authorization for Use or Disclosure of Protected Health Information

1. **I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.**
2. **I understand that I may revoke this authorization at any time by providing written notification to Perfect 10.0 Physical Therapy, PLC, except to the extent that action has been taken in reliance on this authorization.**
3. **I understand that this information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by the Federal Privacy Regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDs-related information, and psychiatric/mental health information.**
4. **My health care and payment for my health care will be affected if I do not sign this form.**
5. **I understand that I will get a copy of this form after I sign it.**

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient or Parent/Legal Guardian/Authorized Person	Date

Records Received By	Date	Relationship to Patient

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Informed Consent for Physical Therapy Services and Acknowledgment and Agreement to Practice Policies

Patient name _____ Date of first visit _____

You will complete this form with your physical therapist at your first appointment.
You may review it in advance, but you will sign it in person.

Before we may provide physical therapy to you, the law requires that we obtain your informed consent. You can only provide us with your informed consent after we have discussed your proposed treatment, the potential risks of that treatment, the potential benefits of that treatment, and information about any possible alternative treatments. To do this, we will need to conduct an initial evaluation.
Therefore, you acknowledge and agree that Perfect 10.0 Physical Therapy, PLC, and its providers will conduct an initial evaluation as described below and provide mobile physical therapy services. Your signature indicates that you consent to receive such services.
Please tell us immediately if you are pregnant, post-surgery, in severe pain, develop new injuries, or begin taking new medications.

Summary of Services

Assessment and treatment may include:

« » General evaluation.

« » Spinal/extremity range of motion and mobility.

« » Balance and stability evaluation.

« » Joint and soft tissue assessment/treatment.

« » Functional movements.

« » Pain/symptom monitoring.

« » Specific examination of:

« » Other:

Risks, Benefits, and Alternatives

The general benefits of receiving physical therapy may include:

- Understand how your body physically moves and functions.
- Understand the behaviors of the pain and symptoms—what makes it better or worse.
- Learn about your anatomy and musculoskeletal function.
- Determine if there is a musculoskeletal or mechanical cause to your condition and symptoms.
- Set a physical therapy plan of care and goals.
- Return to competitive sport or improvement of performance.
- Other:

Informed Consent for Physical Therapy Services and Acknowledgment and Agreement to Practice Policies

Physical therapy is not your only treatment option

Potential alternatives to receiving physical therapy may include:

- Do not receive physical therapy or halt physical therapy at any time.
- Return to your physician for further medical assessment.
- Visit a different physical therapist.

Physical therapy may have certain risks

Potential risks of these physical therapy services may include:

- Increasing your pain or symptoms, either on a short-term or long-term basis.
- Swelling, muscle or joint stiffness, and muscle or joint pain.
- The possibility that treatment will not allow me to identify a specific cause for your condition or symptoms, which can be frustrating or upsetting.
- Other: _____

As described above, my physical therapist has explained the physical therapy services that I will receive and their material risks and benefits. I agree and acknowledge that (1) the physical therapy services may not have the results that I expect or desire; (2) physical therapy is not an exact science; and (3) I have not been given any guarantees about the outcome.

I further acknowledge and agree to the following statements:

☐	I have read and understand this entire document.
☐	I have truthfully provided the information requested.
☐	The treatment and its risks, benefits, side effects, and alternatives have been explained to me.
☐	I have not been given any guarantees about the result of any treatment.
☐	This document binds me.
☐	I agree to pay any applicable cancellation fees.
☐	I have been offered and accepted the Notice of Privacy Practices.
☐	I understand Virginia's direct access to physical therapy.
☐	I authorize the use of my health information for these services.

By signing below, I acknowledge that I am competent, understand this policy, and have been provided material information regarding the proposed care, treatment, service, intervention, or procedure, and the anticipated risks, benefits, side effects, and alternatives, and I have been offered ample time and opportunity to discuss my concerns, and all my questions have been answered to my satisfaction.

Thus, I hereby provide my informed consent to receive the treatment as described in this document.

Patient Name	Date	Signature

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Informed Consent for Physical Therapy Services and Acknowledgment and Agreement to Practice Policies

Acknowledgment & Agreement for Minor Patients

If you are a minor, please ask your parent or guardian to review this document and sign below.

I, the undersigned, am the parent or guardian of the above-referenced patient. I have reviewed this document and give my consent for physical therapy services evaluation and further services by Perfect 10.0 Physical Therapy, PLC, and I agree to the above policies and procedures.

Patient Name	Date	Signature
Parent or Guardian Name	Date	Parent or Guardian Signature

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Fax: 571-410-2230 | Website: www.perfect10pt.org

Dry Needling Consent and Information

This document explains dry needling (as defined below) and its benefits and risks so that you may make an informed decision as to your treatment. Please carefully read this document. Please ask if you have questions about the treatment or need additional information before signing this form. This document applies to activities occurring throughout the entire time period during which you are participating in treatment, whether you participate in one or multiple dry needling sessions, even if there are temporal gaps or if you are taking a break from dry needling treatment.

Dry needling is a form of therapy in which a sterile needle is placed in a myofascial trigger point (a painful knot in the muscle) or tender acupoint. Our therapist is trained to identify tender symptomatic and trigger points throughout the body. Although similar in some respects, dry needling is not acupuncture. Dry Needling does not involve traditional acupuncture theories and is not based on ancient theories or tenets of traditional

Chinese medicine. Perfect 10.0 Physical Therapy, PLC does not guarantee any specific outcome resulting from dry needling. The number of needles and the frequency of the procedure will depend entirely on your condition. Please ask your provider if you have any questions or concerns regarding dry needling and your specific course of treatment. You may stop dry needling at any time for any reason.

Risks and Possible Side Effects: Possible side effects that you may experience may include but are not limited to soreness, redness, itching, burning/stinging, bruising, swelling, and tingling. Less often, there is also the risk of bleeding, nausea, fatigue, infection, temporary paresthesia (pins and needles feeling), dizziness, hematoma, and loss of consciousness. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, this consent will cover this treatment as well as consecutive treatments by this facility. I will update Perfect 10.0 Physical Therapy, PLC if at any point I experience changes in my health status that would change my eligibility for dry needling. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. I am competent, understand this informed consent document, and have been provided material information regarding dry needling and the anticipated risks, benefits, and alternatives. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Please answer the following questions:

1	Have you ever fainted or experienced a seizure?	☐ Yes	☐ No
2	Do you have a pacemaker or any other electrical implants?	☐ Yes	☐ No
3	Are you currently taking anticoagulants (ex: Aspirin, blood thinners)?	☐ Yes	☐ No
4	Are you currently taking antibiotics for an infection?	☐ Yes	☐ No
5	Do you have a damaged heart valve, metal, or other risk of infection?	☐ Yes	☐ No
6	Are you pregnant?	☐ Yes	☐ No
7	Do you suffer from metal implant 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

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DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

You have the right to withdraw consent for this procedure at any time before it is performed.

Patient or Authorized Representative Signature	Date
Relationship to patient (if other than patient)	Patient Name Printed

Physical Therapist Affirmation:

I have explained the procedure indicated above and its attendant benefits, risks, alternatives and consequences to the patient who has indicated understanding thereof and has consented to its performance on the following body part(s): _____

W. Ezara Greene, PT, DPT	as indicated above.
Physical Therapist	**Date**

Perfect 10.0 Physical Therapy, PLC
Phone: 571-252-9131 | Email: egreene@perfect10pt.org
Fax: 571-410-2230 | Website: www.perfect10pt.org

Cancellation & No Show Policy and Financial Agreement

Dear Valued Patient:

The staff of Perfect 10.0 Physical Therapy, PLC, is committed to improving its facilities and service provided to you. If you fail to cancel a scheduled appointment in a timely manner, we cannot use this time for another client, and you will be charged for the entire cost of your missed appointment. We ask that you keep a current credit card on file with us. By providing your credit card information below, you authorize us to charge unpaid balances and fees of any kind to this card. We will save this credit card information in your file for future charges. A premium rate will be applied to all Saturday appointments.

A full session fee of $189 for follow-up physical therapy session, and $372 for a full evaluation by the Doctor of Physical Therapy will be charged to the card below for NO SHOW appointments or cancellations with less than a 24- hour notice.

Additionally, any overdue balances that are the patient's responsibility will be charged to the credit card appointments. below unless the patient specifies a different payment method by contacting our office. A bill will be mailed to you if we are unable to process payment using the credit card below.

- If credit card on file declines, then the amount due will double for inconvenience.
- If payment is not received 24 hours prior to scheduled appointment, then the appointment time will be made available to other patients.
- A service fee applies to all requests for superbills. This includes initial, updated, and end-of-care superbills. No complimentary or courtesy superbills are provided.
- Responsible party for payment will be sent to collections after 90 days of unpaid invoice with a charge of interest every day past due date.
- There is an interest accrual with late fee/unpaid invoices past date of service.

Thank you for your consideration regarding this important matter. Your cooperation is greatly appreciated.

Sincerely,

Perfect 10.0 Physical Therapy, PLC Staff

	(Initial here) I have read and agree to the above terms and conditions.
	(Initial here) I hereby authorize Perfect 10.0 Physical Therapy, PLC to make charges to my credit card for no-show appointments, late cancellations (less than 24 hours), or other agreed upon charges/balances. I understand that I may withdraw this authorization for subsequent charges at any time in writing.

Card Type:

☐	Visa	☐	AMEX
☐	MasterCard	☐	Discover

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

CVV # (on the back of the card): _____

Billing Address: _____

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Cancellation & No Show Policy and Financial Agreement

Client Signature
(Client's Parent/Guardian if under 18)

Date

Printed Name of Client
(Client's Parent/Guardian if under 18)

Signature of Financially Responsible Party

Date

Printed Name of Financially Responsible Party

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