IGNITE
Physical Therapy

PATIENT REGISTRATION FORM

Please Print

Patient Name:_____ Patient Social #:_____

Gender: [ ] Male [ ] Female Birth Date:_____ Age:_____

Address:_____ City,_____ State,_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Authorization to leave voice message, initial:_____ Email:_____

Parent/Guardian:_____ Parent/Guardian Social #:_____

Relationship to Patient:_____ Parent/Guardian Birth Date:_____

Referring Physician:_____ Primary Physician:_____

Emergency Contact:_____ Relationship/Phone:_____

Employer/School/Team Name:

How did you hear of Ignite Physical Therapy?_____

[ ]Doctor [ ]Friend/Family [ ]Social Media/Online [ ]Other:_____

Insurance Information *(To be completed even if insurance card on file)*

Primary Insurance **Secondary Insurance**

Insurance Co Name:_____ Insurance Co Name:_____

Policy Holder:_____ Policy Holder:_____

Policy Holder Birth Date: Policy Holder Birth Date:_____

Relationship to Patient: Relationship to Patient:_____

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize Ignite Physical Therapy to release any personal health information (PHI) required in the course of my examination or treatment to the above stated insurance company, or their affiliates.

Signed (Patient or guardian)_____ Date:_____

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to **Ignite Physical Therapy, 3970 East Riggs Road #1, Chandler, AZ 85249** for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or guardian)_____ Date:_____

IGNITE
Physical Therapy

IGNITE PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION, INCLUDING HOUSE BILL 2045. PLEASE REVIEW IT CAREFULLY.

IGNITE PHYSICAL THERAPY LEGAL DUTY

is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow these practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Ignite Physical Therapy uses your personal health information primarily for treatment; obtaining payment of treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Ignite Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Ignite Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.
In any other situation, Ignite Physical Therapy policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Ignite Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the clinic and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate information or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Ignite Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

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Physical Therapy

CONCERNS AND COMPLAINTS

If you are concerned that Ignite Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the following person:

Tara Poloni
Tara@igniteptaz.com
480-833-0202

You may also file a complaint with the Department of Health and Human Services via mail, fax, email, or the OCR Complaint Portal. Additional information can also be found on their website at www.hhs.gov/ocr/hipaa/.

You will not be retaliated against for filing a complaint.

HOUSE BILL 2045

Effective December 31, 2013, in accordance with the Arizona House Bill 2045 which requires healthcare providers who are owners or employees of a legal entity with three or more licensed healthcare providers to post their direct pay prices for their 25 most commonly provided services online or make them available upon request. The bill specifies how services are to be identified, how often the list is to be updated and the timeframe from which the list is to be determined.

HB 2045 also requires healthcare providers to obtain a person's signature on a notice before accepting direct payment from that person if the healthcare provider is contracted as a network provider for a healthcare system in which the person is an enrollee. For more information about House Bill 2045, please visit the website of the Arizona State Legislature, azleg.gov. You may search for the bill using their Bill Number Search. All patients or their guardians must read and acknowledge the following guidelines.

MEMBER DIRECT PAYMENT NOTIFICATION – PROVIDER

Arizona state constitution permits you to pay a healthcare provider directly for health care services. Before you make any agreement to do so, please read the following important information.
If you have active health insurance coverage and your healthcare provider is contracting with your health insurance provider, the following guidelines apply:

1. You may not be required to pay the healthcare provider directly for the services covered by your health insurance plan, except for the cost-share amounts that you are obligated to pay under your plan; such as co-payments, co-insurance, and deductible amounts.

2. Your healthcare provider's agreement with your health insurance plan may prevent the healthcare provider from billing you for the difference between the healthcare providers billed charges and the amount allowed by your health insurance plan for covered services.

3. If you pay directly for health care service(s), your healthcare provider is not responsible for submitting claim documentation to your health insurance plan. Before paying your claims, your health insurance plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your health insurance plan.

4. If you do not pay directly for health care service(s), your healthcare provider may be responsible for submitting claim documentation to your health insurance plan for the health care service(s).

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PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Ignite Physical Therapy Notice of Information Practices.

- I understand that Ignite Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.
- I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice.
- I also understand that Ignite Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.
- I hereby consent to the use and disclosure of my personal health information for purposes as noted in Ignite Physical Therapy Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
- Your signature below acknowledges that you received House Bill 2045 notice before paying this provider for healthcare service(s).

Patient Name: _____

Signature of responsible party: _____

Printed Name of signer: _____

Date: _____

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Patient Name: _____

Signature of responsible party: _____

Printed Name of signer: _____

Date: _____

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FINANCIAL POLICY

Thank you for being a valued patient of Ignite Physical Therapy! Please take a moment to review and sign our policies.

Insurance/Financial Policies **Initial** _____

- We are contracted with most insurance plans. These plans may have co-payment, co-insurance or deductible. Co-payment is due at the time of service. Payment plans for non-covered services or cash pay can be arranged.
- Each insurance plan is different and has its own policies on what is and is not a covered benefit. It is your responsibility to know what is covered (we would be happy to verify your benefits as a courtesy, although benefits change and may not be guaranteed at time of service, therefore falls under your responsibility), and which benefit fall under your plan.

Delinquent Accounts **Initial** _____

- Account balances should be paid within 30 days of the account statement. A late fee of $15.00 will be assessed after for each month.
- Outstanding balances past 90 days will be transferred to a collection agency, unless prior arrangements have been made with us.

Cancellation of Appointments/No Show Policy **Initial** _____

- When an appointment is not kept, it creates an unused appointment slot that could have been used for another patient. It is very important that you notify us if you are unable to make your appointment.
- If for any reason you need to cancel or reschedule an appointment, please notify our office 24 hours in advance to avoid a fee of $25.00.
- A no-show occurrence will be subject to a $25 charge for an office visit.

Returned Checks **Initial** _____

- There will be a $35.00 service fee for any check returned for insufficient funds.
- After 2 returned checks, we will not longer accept checks as your form of payment.

Concerns: If you have any concerns, please feel free to speak to our office manager so that we may address any issues. Thank you for being a valued patient.

I have read and understand the above policies.

Patient Signature _____

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ELECTRONIC COMMUNICATION CONSENT

Patient Name:_____

Email:_____

Cell Phone:_____

Appointment Reminders

Complete this form and sign below to give your permission for Ignite Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

[ ] **E-MAIL OPTION**: Ignite Physical Therapy may send email messages to confirm my upcoming appointments.

[ ] TEXT OPTION: Ignite Physical Therapy may send cell phone text messages* to confirm my upcoming appointments. Please indicate your cell phone carrier:

**Normal text messaging rates may apply.*

ALLTel	AT&T	Boost Mobile	Cingular	Cricket Wireless
Metrocell	Metro PCS	Nextel	Quest	Sprint PCS
T-Mobile	US Cellular	Verizon	Virgin Mobile	

Text Message Surveys

In an effort to provide an outstanding customer experience and to provide the highest possible quality of care, Ignite Physical Therapy may send you text messages about your visit and other educational content related to your treatment. You may opt-out at any time by replying "STOP" to any text you receive.

(initial)

Join our Mailing List

Stay connected with all of the latest updates from Ignite Physical Therapy. By providing your email address, you agree to receive periodic updates from Ignite Physical Therapy. You may opt-out at any time by unsubscribing via the link at the bottom of every email.

(initial)

Signature:_____Date:_____

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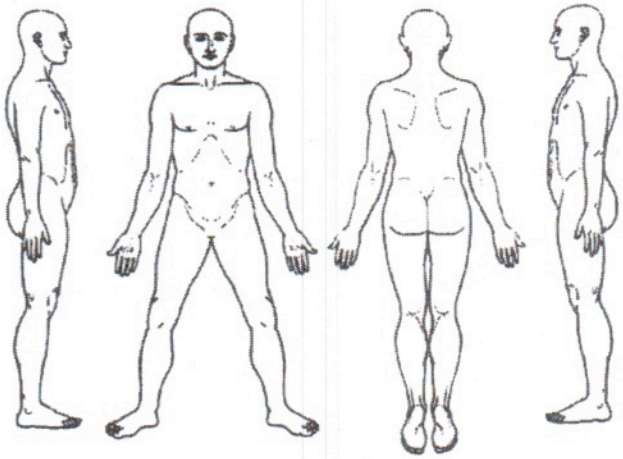
INITIAL SELF-EVALUATION FORM

NAME: **DATE:**

PRESENT CONDITION: PAIN OR TENSION

Please shade in the area or areas where you are experiencing pain/symptoms. You may use more than one description for each area.



DESCRIPTION OF PAIN:

Use the following descriptions of pain to indicate the type of pain in each area that you shade by drawing an arrow from each specific type of pain to that area you have shaded.

o **Weakness** o **Sharp** o **Aching** o **Numbness/Tingling**

o Sever Pain o Dull o Stabbing o Throbbing

o Moderate o Burning o Radiating o Aching

SEVERITY OF PAIN:

Please list each symptom that you are experiencing and rate each on a scale of 0 -10. (Key: 10 being take me to the hospital type pain, and 0 being no pain.)

1. _____ ____/__10__
2. _____ ____/__10__
3. _____ ____/__10__

Have your symptoms become (circle one):

Better **Worse** **Remained the same**

Patient Signature: _____

HISTORY OF CURRENT CONDITION:

Age:_____ Date of Discomfort ____/____/____

What do you think initially caused your pain? _____

_____

How Often do you experience this pain? (Describe) _____

_____

What do you think makes your symptoms worse?

o **Sitting** o **Standing** o **Lifting** o **Bending**

o Other: _____

What eases your symptoms? _____

Have you had related surgery? ___Yes ___No

Please Describe: _____

Are you taking any medication? If so, please list: _____

_____

Are you taking any supplements? If so, please list: _____

_____

Are you currently under the care of a physician? __Yes ___No

Have you ever had physical therapy? __Yes ___No

Do you have, or have you had any of the following?

Y/N Diabetes Y/N Headaches
Y/N Chest Pains/Angina Y/N High Blood Pressure
Y/N Bowel/Bladder Issues Y/N Smoking
Y/N Osteoporosis Y/N Fractures
Y/N Shortness of Breath Y/N Hernia
Y/N Nausea/Vomiting Y/N Hypoglycemia
Y/N Dizziness/Fainting Y/N Asthma
Y/N Urine Leakage Y/N Cancer
Y/N Rheumatoid Arthritis Y/N Heart Attack
Y/N Kidney Problems Y/N Stroke
Y/N Osteoarthritis Y/N Skin Abnormalities
Y/N Heart Palpitations Y/N Seizures
Y/N Liver/Gallbladder Y/N Surgeries

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Dry Needling Patient Consent to Treat

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 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-induced 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 a 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 n 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 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 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 2 hours? YES/NO

Single Use, disposable needles are used in this clinic.

STATEMENT OF CONSENT

I confirm that I have read or understand the above information, and I consent to have dry needling treatments. I understand that I can refuse treatment at any time.

Signature; _____

Printed Name: _____

Date: _____

3970 East Riggs Road #1, Chandler, AZ 85249 | Ph. 480.883.0202

IGNITE PHYSICAL THERAPY
FACILITY FEE:

ALL NEW PATIENTS AND/OR NEW EVALS WILL BE CHARGED A $39.00 FACILITY FEE. THIS FEE INCLUDES ALL OF THE FOLLOWING:

***SANITIZING FEES**
***CLEANING SUPPLIES**
***SUPPLY FEE**
***DRY NEEDLES**
***THERABANDS**
***KINESIO TAPE**
***CUPPING**

SIGNATURE: _____ **DATE:** _____