MOBILITY FIT
PHYSICAL THERAPY

CLIENT DEMOGRAPHIC

DEMOGRAPHICS

First Name_____ Last Name_____ MI_____

DOB____/____/____ Cell Number_____ Alt. Number_____

Address_____ City_____ State_____ ZIP Code_____

Social Security Number_____ Email Address_____

How did you hear about us?_____

EMPLOYMENT INFORMATION

Occupation_____

Employer_____Employer Phone Number_____

INSURANCE INFORMATION

Person Responsible for Payment (Subscriber)_____ DOB____/____/____

Address (If Different)_____ City_____ State____ ZIP Code_____

Cell Number_____ Social Security Number_____

Name of Insurance Provider_____ ID Number (As Appears on Card)_____

Group Number_____

EMERGENCY CONTACT INFO

Name of Contact_____ Relationship to Client_____

Cell Number_____ Home Number_____

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the Mobility Fit Physical Therapy, LLC. I understand that I am financially responsible for any balance. I authorize MOBILITY FIT PHYSICAL THERAPY LLC or insurance company to release any information required to process my claims.

Client/Guardian Signature_____ Date____/____/____

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MEDICAL QUESTIONNAIRE

Name_____ Today's Date____/____/____

Describe the injury/problem that brings you to Mobility Fit Physical Therapy. How did the injury occur?

_____

_____

Side of injury/problem LEFT or RIGHT

Approximate date of injury/onset of problem:_____

What activities/specific exercises are you unable to perform?

_____

Describe your symptoms. What *eases* them and what *aggravates* them?

_____

_____

Have you previously received treatment for this problem (PT, Chiropractic, etc)?

YES or NO

If YES, please explain all the treatment you have received:

_____

Have you had any tests for this problem? (Circle all that apply)

MRI CT Scan X-RAY Other:_____

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MEDICAL QUESTIONNAIRE

Please list all surgeries or illnesses for which you have been hospitalized or treated, including approximate date.

DATE: SURGERY/TREATMENT REASON

_____

_____

MEDICAL HISTORY (Please check all that apply)

- ☐ Angina/Chest Pain
- ☐ Asthma
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Blood Clot
- ☐ Bowel or Bladder Problems
- ☐ Carpel Tunnel Syndrome
- ☐ Chest/Abdominal Surgery
- ☐ Coronary Artery Disease
- ☐ Cancer
- ☐ Depression
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Low Blood Pressure
- ☐ Migraine/Headaches
- ☐ Major Spinal Injury
- ☐ MRSA
- ☐ Nicotine Use/Consumption
- ☐ Osteoporosis
- ☐ Pacemaker/Nitroglycerin
- ☐ Poor Circulation/Raynaud's
- ☐ Seizures
- ☐ Traumatic Injury/Motor Vehicle Accident
- ☐ Fractures

  _____

  _____

  _____

- ☐ Other

  _____

  _____

  _____

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CLIENT CONSENT FORM

1. I, the Client, or parent/guardian of the client, _____, do hereby voluntarily consent to such care encompassing evaluation procedures and medical treatments sought by myself and/or as ordered by a physical therapist from Mobility Fit Physical Therapy.

2. I authorize the staff of Mobility Fit Physical Therapy to undertake such procedures and treatments as deemed appropriate to improve my condition.

3. It is recognized that the at-home program I am given by Mobility Fit Physical Therapy is a necessary component to the improvement of my condition, and therefore my responsibility to carry out in order to make these improvements in a timely manner.

4. I authorize that I am responsible for understanding my contract with my insurance provider and that I may be contacted by an employee of Mobility Fit Physical Therapy to discuss my Physical Therapy coverage.

5. I hereby authorize Mobility Fit Physical Therapy to release medical information regarding myself and my current condition to my insurance company, as well as referring, consulting, treating physicians or other medical providers as needed to support continuity of care.

6. I understand that I have the right to a full explanation of treatments and procedures. I understand that I have the right to refuse any treatment; but, in doing so, I also understand that the desired outcome of my treatment plan may be negatively affected.

7. I consent to the use of still photography and/or video analysis as a component of my physical therapy services. These will be used as necessary for my plan of care, and I will be made aware when these photos or videos are being taken. I understand that these photo's and/or videos are an important component of monitoring my progress and treatment.

Please Initial_____

8. I give my permission to use any pictures and/or videos taken for purposes including but not limited to social media postings, publications, advertisements, educational material, or in any medium now known or later developed, including the internet.

_____ ***I DO give my consent*** *to Mobility Fit Physical Therapy to use my name and likeness to promote the above mentioned. (Line 8)*
Initial

_____ ***I DO NOT give my consent*** *to Mobility Fit Physical Therapy to use my name and likeness to promote the above mentioned. (Line 8)*
Initial

9. I have fully read the above in its entirety and I fully understand and agree to its contents.

_____ _____

Print Name of Client Signature of Client

Date____/____/____

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CLIENT PAYMENT AGREEMENT

Mobility Fit Physical Therapy strives to provide you with a clear understanding of your financial responsibility with respect to the medical services we provide. Please read our policies below and provide your signatures.

We will gladly contact your insurance company to obtain your current benefit coverage. However, that information can be used only as a guideline and does not guarantee medical benefits or payment.

_____ *Initial* I understand that it is ultimately my responsibility to know and understand my benefit coverage for Physical Therapy.

_____ *Initial* I understand that my insurance company will determine and pay for services according to my plan benefits

_____ *Initial* I understand it is my responsibility, and agree to; pay all co-pays, co-insurance, or deductibles at the time of service.

_____ *Initial* I understand that it is my responsibility to pay all balances for uncovered services within 30 days of my discharge from PT.

_____ *Initial* I authorize Mobility Fit Physical Therapy to release my medical information to insurance companies, medical billing employees, physicians, and all other parties that may be involved in my claim.

I wish to accept the insurance submission option.

_____ ____/____/____
Client Signature Date

I have fully read, understand, and agree to the above Mobility Fit PT payment requirements. I authorize Mobility Fit PT to release pertinent medical information related to my insurance.

_____
Print Name of Client

_____ ____/____/____
Client Signature (or responsible party if minor) Date

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WHAT TO EXPECT AFTER FUNCTIONAL DRY NEEDLING® TREATMENTS

How will I feel after a session of FDN?

- You may feel some soreness immediately after treatment in the area of the body you were treated. This does not always occur but should be expected and is considered normal. It can also take up to a few hours, or even until the next day, to feel an onset of soreness. The soreness may vary from person to person and based on the area of the body that was treated, but it typically feels like you had an intense workout at the gym. Soreness typically lasts 24-48 hours. Make sure to indicate to your provider at a follow-up appointment how long the soreness lasted.
- Bruising from the treatment is possible, somewhat uncommon, but is not of concern. Some areas are more likely to bruise than others including the shoulders, chest, face and portions of the extremities. Large bruising rarely occurs, but is possible. Use ice to help decrease the bruising and if you feel concern please call your provider.
- It is common to feel tired/fatigued, energized, emotional, giggly or "out of it" after treatment. This is a normal response that can last up to an hour or two after treatment. If this lasts beyond a day contact your provider as a precaution.
- There are times when treatment may actually exacerbate your symptoms. This is normal and may indicate that you need to follow up sooner with your practitioner to continue treatment. If this continues past the 24-48 hour window, keep note of it, as this can help your provider adjust your treatment plan if needed based on your report. This does not mean FDN cannot help your condition.

What should I do after my treatment and what is recommended?

We highly recommended increasing your water intake for the next 24 hours after treatment to help avoid or reduce soreness. We also recommend soaking in a hot bath or hot tub to help relieve post treatment soreness, and to soften the symptoms associated with the treatment you received. After dry needling treatment, you may do the following based on your comfort level. Please note that if it hurts or exacerbates your symptoms, then discontinuing the activity is probably best.

- Work out and/or stretch.
- Participate in normal physical activity.
- Massage the area.
- Use heat or ice as preferred for post treatment soreness.
- If you have prescription medications, continue to take them as prescribed.

What should I avoid after treatment?

- Unfamiliar physical activities or sports.
- Doing more than you normally do.
- Excessive alcohol intake.

If you are feeling light headed, or experience difficulty breathing, chest pain, or any other concerning symptoms after treatment, call us immediately. If you are unable to get a hold of us, please call your physician.

Please keep this sheet for your records and reference.

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FUNCTIONAL DRY NEEDLING® CONSENT AND REQUEST FOR PROCEDURE

Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Your physical therapist trained by KinetaCore® has met requirements for Level 1 (27 hours of training) competency in Functional Dry Needling®, and is currently in training to become a certified Functional Dry Needling® Practitioner. All training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Client'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, thus this consent will cover this treatment as well as consecutive treatments by this facility. 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. 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.

Procedure: I, _____, authorize Mobility Fit Physical Therapy to perform Functional Dry Needling® for my diagnosis of _____.

Please answer the following questions:

Are you pregnant? Yes No **Are you immunocompromised?** Yes No

Are you taking blood thinners? Yes No

☐ Client was offered copy of consent and refused ☐ I was given the 'What to Expect' form

☐ Client was given copy of consent

☐ ***I understand there is an additional $15 supply charge due at the time of service for this treatment, not covered by insurance. Pre-payment for future sessions are accepted as well.***

☐ I understand that the practitioner applying this technique has competency in Functional Dry Needling®, and has completed the necessary certifications and course work.

Client Signature: _____ Date: ____/____/____

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CANCELLATION AND NO-SHOW POLICY

Our goal is to provide a physical therapy experience far superior to any you have previously known or experienced. This means that you will be scheduling one-on-one sessions with one of our doctors of physical therapy. Each and every appointment space is important; therefore our no-show and late cancellation policies are in place in order to maximize the available offerings for our clients.

Cancellation Policy & No-Show Policy:

- With the high demand for available slots, we require 24-hours advanced notice to cancel an appointment.

- Cancellations or a no-show with less than 24-hours notice will receive a charge to their account, as follows:
  - First late cancellation/no-show: $35
  - Second late cancellation/no-show: $45
  - Third late cancellation/no-show: $70 and discharged from therapy

By signing below, I understand that after one no-show or late cancellation, my account will be charged. I understand that this policy is to encourage my dedication to the process and to ensure success for all.

Client Signature: _____ Date: ____/____/____