ADVANCED MUSCLE RECOVERY
Dry Needle Physical Therapy

maria@indydryneedle.com
(317) 690-0611
www.indydryneedle.com

New Patient Forms

CONTACT INFORMATION

Name: _____ Today's Date: _____

Address: _____ City, State, Zip: _____

Phone: _____ Date of Birth: _____

Email: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____

Referring Physician: _____

Emergency Contact: _____ Emergency Phone: _____

REFERRED PHYSICIAN POLICY: If you have referred yourself to physical therapy, Indiana state law requires a physician's order after 42 consecutive calendar days.

HEALTH CONDITIONS

Have you ever had any of the following conditions or diagnoses? Please check all that apply:

- ☐ Cancer
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Epilepsy/Seizures
- ☐ Multiple Sclerosis
- ☐ Head Injury
- ☐ Osteoporosis
- ☐ Hypothyroid/Hyperthyroid
- ☐ Emphysema/Chronic Bronchitis
- ☐ Asthma
- ☐ Allergies
- ☐ Latex Sensitivity
- ☐ Anemia
- ☐ Low Back Pain
- ☐ Sacroiliac/Tailbone Pain
- ☐ Alcoholism/Drug Problem
- ☐ Depression
- ☐ Bone Fracture
- ☐ Sports Injuries
- ☐ Pelvic Pain
- ☐ Suicidal Thoughts
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Stress Fracture
- ☐ Rheumatoid Arthritis
- ☐ Joint Replacement
- ☐ Physical Or Sexual Abuse
- ☐ TMJ/Neck Pain
- ☐ Hearing Loss/Problems
- ☐ Headaches
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Irritable Bowel Disease
- ☐ Hepatitis
- ☐ Vision/Eye Problems
- ☐ Raynaud's (Cold Hands & Feet)

COVID-19 VACCINATION

Have you been vaccinated for COVID-19?

- ☐ Moderna — 1st Vaccine Date: _____ 2nd Vaccine Date: _____ Booster Date: _____
- ☐ Pfizer — 1st Vaccine Date: _____ 2nd Vaccine Date: _____ Booster Date: _____
- ☐ Johnson & Johnson — Vaccine Date: _____
- ☐ Unvaccinated

SYMPTOMS OR ISSUES

Describe the primary issue or problem that brought you here today: _____

What makes your symptoms better or worse? _____

If pain is present, please rate it on a scale of 0-10: 0 (no pain) to 10 (extreme pain)

At it's worst: _____ At it's best: _____

At present: _____ At night (sleeping): _____

If your first episode of the problem related to an accident or specific incident, please describe: _____

Describe any treatments that you have received for this problem: _____

List any other concerns not yet covered: _____

MEDICATIONS, VITAMINS, AND SUPPLEMENTS

Medicine: _____ Purpose / Dosage: _____

Medicine: _____ Purpose / Dosage: _____

Medicine: _____ Purpose / Dosage: _____

Medicine: _____ Purpose / Dosage: _____

Medicine: _____ Purpose / Dosage: _____

Medicine: _____ Purpose / Dosage: _____

Medicine: _____ Purpose / Dosage: _____

Medicine: _____ Purpose / Dosage: _____

Vitamins: _____

Supplements: _____

Allergies: _____

☐ I do not take any medications, vitamins, or supplements.

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DRY NEEDLING QUESTIONNAIRE

Have you ever fainted or have a real fear of needles?
- ☐ Yes
- ☐ No

Do you have a pacemaker or any other electrical implant?
- ☐ Yes
- ☐ No

Are you taking any anticoagulants?
(Blood thinners: warfarin, coumadin)
- ☐ Yes
- ☐ No

Are you currently taking any antibiotics for an infection?
- ☐ Yes
- ☐ No

Do you have any metal in your body?
- ☐ Yes
- ☐ No

Do you have any allergies to metal?
- ☐ Yes
- ☐ No

Are you pregnant or currently trying?
- ☐ Yes
- ☐ No

Are you diabetic or have an impairment for wound healing?
- ☐ Yes
- ☐ No

Have you ever been diagnosed with Hepatitis B or C, HIV orany other infectious disease?
- ☐ Yes
- ☐ No

Have you had any surgical procedures within the past 3 months?
- ☐ Yes
- ☐ No

Do you have or have you ever had a pneumothorax? (Collapsed lung)
- ☐ Yes
- ☐ No

Do you have a history of, or are you currently receiving treatment for cancer?
- ☐ Yes
- ☐ No

Have you had a mastectomy or any history of lymphedema?
- ☐ Yes
- ☐ No

Do you have any type of implant anywhere in your body?
- ☐ Yes
- ☐ No

Do you have a vascular disease or varicose veins?
- ☐ Yes
- ☐ No

Do you have scoliosis?
- ☐ Yes
- ☐ No

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ADVANCED MUSCLE RECOVERY PHYSICAL THERAPY, LLC

DRY NEEDLING CONSENT AND REQUEST FOR PROCEDURE

Dry needling (DN) 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 is intended to promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective.

DN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, DN will not be effective for everyone, and 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 DN 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 include shortness of breath and may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung, which is a rare complication. 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.

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, thus this consent will cover this treatment as well as consecutive treatments by Advanced Muscle Recovery Physical Therapy, LLC. 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 dry needling. I also consent to any measures necessary to correct complications which may result.

PROCEDURE: I, _____, authorize Maria Dunlop with Advanced Muscle Recovery Physical Therapy, LLC to perform Dry Needling.

Please answer all the questions of the previous page before signing this form.
You can withdraw consent for dry needling at any time before it is performed.

_____ _____ _____
Patient or Authorized Representative Date Time

_____ _____
Relationship to patient (if other than patient) Patient Name (printed)

PHYSICAL THERAPIST AFFIRMATION: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

_____ _____ _____
Physical Therapist Date Time

Payment Agreement

Thank you for choosing Maria Dunlop, PT as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since we are not enrolled providers, we cannot submit claims to Medicare *and* Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. Therefore, by choosing our services, you are exercising your right to privacy and electing, of your own free will, not to use your Medicare benefits. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.
    - **Medicare Advantage Plans and Medicare Replacement Plans.** We are not in-network with any Medicare Advantage or Replacement Plans. If your Medicare Advantage or Replacement Plan offers out-of-network benefits for services received from providers not enrolled with Medicare and we don't have to directly submit your claims, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, you should be prepared that your health plan may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your health plan to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
    - **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other visits.
    - **Use of Health Savings Accounts (HSA).** If you purchase a pre-paid package plan through your HSA account we will give you a receipt for the pre-paid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.
    - **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your

HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.

- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- **Workers' Compensation Policy.** If your injury is work related, we will bill the workers' compensation carrier if you have filed an injury report. If you have not filed an injury report, your injury is later determined not to be not work related or any of the treatment you receive is denied, you will be responsible for paying our claims. Therefore, you agree to notify us immediately if you receive notice of any controversy from your employer or the workers' compensation insurance carrier.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **Service Termination Policy.** If we determine at any time that conditions in your home create a potentially unsafe environment for our providers, we may, at our sole discretion, terminate our services with you. If we do so, we will make reasonable efforts to refer you to the services you need to resolve the issue that is causing a potentially unsafe environment. If you have prepaid for any services, we will refund any monies paid for services not yet received as of the date or our termination.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Maria Dunlop, PT and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Maria Dunlop, PT and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Signature of Provider Representative

A photocopy of this agreement is to be considered valid, the same as if it was the original.