Office Policies:

Please initial each allotted space, and sign and date below as acknowledgement of North Boulder Physical Therapy's office policies.

Acknowledgement of Receipt of Notice of Privacy Practices:

I have received the Notice of Privacy Practices from North Boulder Physical Therapy Rehabilitation, LLC. These are located at the front desk upon check in.

Initial: ___________________

Missed Appointments:

Unless cancelled at least **24 hours** in advance, **our policy is to charge $45.00 for each missed appointment.** The courtesy of your phone call allows us to schedule patients on our waitlist. If we are closed please leave a voicemail. This charge is NOT covered or billed to your insurance and is due at the time of your next appointment.

Initial: ___________________

Supplies and Equipment:

I agree to pay for supplies in full on the date of service. I understand that North Boulder Physical Therapy is not considered a durable medical goods provider, and that most insurance companies will not reimburse for supplies such as orthotics, equipment, or any other durable medical good. If my insurance were to cover supplies, I understand that I will only be reimbursed the amount of money paid to North Boulder PT by insurance.

Initial: ___________________

Release of Information:

I authorize______________________________**(referring physician's name)**and ___________________________**(primary care physician)** to release any of my medical records, x-rays, or reports to North Boulder PT for the purpose of obtaining medical information pertaining to my treatment. I also authorize North Boulder PT to release my medical records to the above named physician.

Initial: ___________________

Assignment of Benefits:

I hereby assign payment directly to North Boulder Physical Therapy, who represents this clinic to Payor Groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident, and the medical benefits are exhausted such that financial responsibility reverts to my health insurance, I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment.

Initial: ___________________

Changes in Billing or Insurance Information:

I understand it is my responsibility to update, in a timely manner and in writing, North Boulder Physical Therapy of any changes to my insurance coverage or personal information such as address, phone numbers, and name changes.

Initial: ___________________

Quote of Benefits:

I understand that a quote of insurance benefits is not a guarantee of payment and that I am responsible for any applicable deductibles or co-pays. I understand that it is my responsibility to verify my benefits and whether North Boulder PT is in network with my health insurance. A quote of benefits is provided by North Boulder PT as a courtesy and North Boulder PT is not responsible for misquoted benefits.

Initial: ___________________

Signature: ______________________________________ Date:___________________

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PERSONAL INFORMATION DATE: ______

Name (Last, First):______________________DOB:____/____/____

Occupation:______________________

EMERGENCY CONTACT INFORMATION

Primary Contact ______________________ Phone: ( ) ____-______

Secondary Contact______________________ Phone: ( ) ____-______

MEDICAL HISTORY

Please check ☑ all conditions that apply to you:

☐Allergies (Specify:________)	☐Diabetes	☐Gastrointestinal/IBS	☐Stroke/TIA
☐Anemia	☐Dizziness/Vertigo	☐Latex allergy	☐Traumatic brain injury
☐Arthritis	☐Fatigue/Energy loss	☐Multiple Sclerosis	☐Vision/hearing impaired (circle)
☐Asthma/COPD	☐Fibromyalgia	☐Neurological condition	☐Weight loss/gain (circle)
☐Bladder/bowel dysfunction	☐Fracture(s)	☐Osteoporosis/Osteopenia	☐Other:__________
☐Blood clots/thrombosis	☐Headaches	☐Pacemaker/implant	☐Other:__________
☐Cancer (Specify:________)	☐Hepatitis A B or C	☐Parkinson's Disease	☐Other:__________
☐Cardiovascular disease	☐HIV/AIDs	☐Pregnant or may be pregnant	
☐Depression	☐Hypertension	☐Seizures	

MEDICATIONS

Please list current medications, vitamins and supplements (you may attach list or write on back if you need more room)

	Name	*Dosage/Frequency*	*What do you take this for?*
1.	______	______	______
2.	______	______	______
3.	______	______	______
4.	______	______	______
5.	______	______	______

SURGICAL HISTORY

Please List Prior Surgeries (you may attach list or write on back if you need more room):

	Surgery Performed	*Date*
1.	______	______
2.	______	______
3.	______	______
4.	______	______
5.	______	______

PHYSICAL THERAPY INTAKE QUESTIONNAIRE

Name:______________________________**DOB:**____/_____/____ **Date:**____________

CURRENT CONDITION

What is the injury or condition that brings you in today?

____

When did the problem start? ________________________

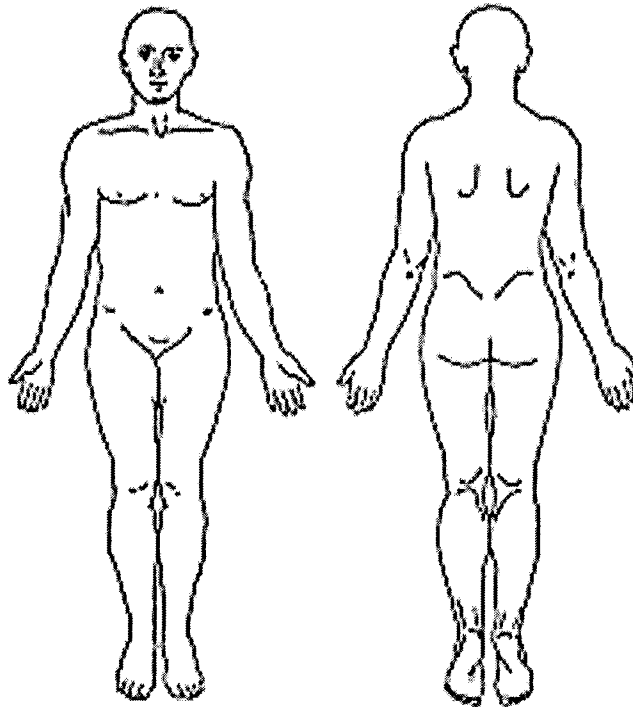
How Did You Hear About Our Clinic?			
Your Doctor		Friend/Family	
Previous Patient		Newspaper	
Internet		Other	

How did you injure yourself? ☐ Aging ☐ Daily Life ☐Fall ☐Motor Vehicle ☐ Repetition ☐Work injury ☐Other:______________________________

Did you have surgery? ☐ Yes ☐ No If yes, surgery performed:____________________ __Date: ____________

Have you had any recent imaging? ☐XRay ☐ MRI ☐ CT Scan ☐ Other:____________

On the diagram below, please indicate the area where you are experiencing the symptoms for which you are seeking treatment today:



Please circle and indicate the numbers which correspond to your pain at its ***best, worst, and currently:***

BEST	0	1	2	3	4	5	6	7	8	9	10
WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENTLY	0	1	2	3	4	5	6	7	8	9	10

GOALS

Please list any specific goals, issues or concerns you may have with your physical therapy:

1. ____
2. ____
3. ____

A Sister Clinic To North Boulder Pilates

Boulder Medical Center
2750 Broadway
Boulder, Colorado 80304-3586
Phone (303) 440-3034
Fax (303) 402-1665

3000 Center Green Drive, Suite 110
NW Corner of Valmont & Foothills Pkwy.
Boulder, Colorado 80301
Phone (303) 413-9903
Fax (303) 413-9907

Please Print Your Name ______________________

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 is 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 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 unless you are taking a blood thinner.

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 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.

Notice of Insurance Non-Coverage:

With the information available at this time we have been informed that your insurance will not pay for the dry needles used in your treatment. The incurred cost to you is $6.99 per treatment. All other services will be billed accordingly through your insurance and will not be affected by the non-coverage of these needles.

Often, insurance companies do not pay for all health care costs. Although your insurance may not pay for a particular item or service, this does not mean you should not receive it. There is good research to support our recommendation for the use of dry needling.

By signing below you acknowledge that the dry needles are not covered under your insurance policy and agree to be fully responsible for a payment of $6.99 per treatment.

Signature ______________________ Date __________

Debra J. Layne, PT
Lic. #1413
Denise E. Baugh, MSPT
Lic. #4699
Ted Layne, PT, ATC
Lic. #1542
Angela Cook,MSPT
lic # PTL00007144
Christine Shaw, PT, DPT
Lic # PTL.0014909

Lee Brennan, MSPT
Lic. #6404
Terri Handy, MSPT
Lic. #8126
Libby White, DPT
Lic # 13662
Michelle Harris, PT
lic # PTL.00003553
Meredith Hoerske, OT
lic #OT.10327

Laura B. Shove, MS, PT
Lic. #4229
Michelle Harris, PT
Lic. #3553
Angela Cook, MSPT
Lic# 7144
Sabina Busby, PT, DPT
Lic # PTL0015687
Ryn Proctor, PT, DPT
Lic # PTL0014974

Katie Gavin, MSPT
Lic#13005
Seneca Webb,DPT
Lic.# 9678
Karen Echery, MSPT
Lic. #8359
Jeffrey Paulsen, PT, DPT
Lic # PTL.0010911
Kimberlee Axelrod, PT, DPT
Lic # PTL.0015804