DATE OF EVAL: _____ PT: _____ TO#: _____

PATIENT NAME _____ **DOB**_____SS_____ **SEX:** M / F

MAILING ADDRESS_____ **CITY** _____ **STATE** _____ **ZIP** _____

PRIMARY PHONE _____ Cell / Home **REMINDER** ☐ Call ☐ Text ☐ None Secondary Phone**:** _____Cell / Home

EMAIL _____ **WOULD YOU LIKE TO RECEIVE ELECTRONIC STATEMENTS?** ☐ Yes ☐ No

REASON FOR VISIT_____**INJURY RELATED TO** ☐Work ☐Auto ☐N/A

REFERRING PROVIDER _____ **PRIMARY PROVIDER**_____

EMERGENCY CONTACT_____ **PHONE** _____**RELATIONSHIP**_____

MEDICARE ONLY- Have you had Home Care in the past 60 days? Y / N Agency Name:_____

PRIMARY INSURANCE INFORMATION- PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

PRIMARY INSURANCE_____ **ID** _____**GROUP #** _____

Policy Holder_____ **Relationship**_____ **DOB**_____

Do you have a secondary insurance? ☐ Yes ☐ No (if yes, please make sure that information is listed below)

SECONDARY INSURANCE INFORMATION- PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

SECONDARY INSURANCE_____ **ID** _____**GROUP #** _____

Policy Holder_____ **Relationship**_____ **DOB**_____

WC/AUTO CARRIER_____ **CLAIM #** _____**INJURY DATE / STATE** _____

ADJUSTER NAME_____ **PHONE**_____ **FAX**_____

CASE MANAGER_____ **PHONE**_____ **FAX**_____

Billing Address _____ Claim Open? Y / N

Auth or U/R Required? Y / N U /R PHONE _____ U/R Fax _____

Medical Bill Status _____ Body Part(s) Involved/Injury _____

By signing below, I acknowledge that all of the above information is accurate. I have supplied copies of all of my health insurance cards to the front desk upon registration. I understand that if my health insurance is not on file or I fail to supply the correct insurance information, I may be responsible for all balances. IF at any time any of this information changes, I am aware that I must inform the facility immediately to avoid unnecessary patient balances.

Patient/Guardian Signature: _____ **Date:** _____

Medical History Questionnaire

Dba InMotion Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

Patient Name _____ **Subscriber ID #** _____ **DOB** _____

Are you currently working? ☐ Yes ☐ No ☐ Retired **If Yes, what is your occupation?** _____

Why did you select our facility? ☐ Medical Provider Referral ☐ Returning Patient ☐ Family/Friend ☐ Web/Internet ☐ Workshop/Discovery Visit ☐ Newsletter ☐ Other _____

Describe your current problem and how it began _____

Onset or Surgery Date _____

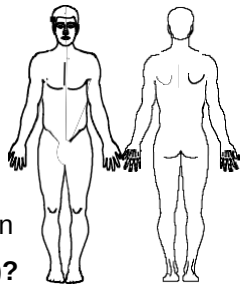
List any diagnostics/tests you have had due to your *current* condition_____

How often are your symptoms present throughout the day?

☐ Constantly (76-100% of the day) ☐ Frequently (51%-75% of the day)

☐ Occasionally (26%-50% of the day) ☐ Intermittently (0%-25% of the day)

Indicate below where you have pain or other symptoms



Describe the nature of your pain ☐ Sharp ☐ Dull Ache ☐ Numbness ☐ Shooting ☐ Burning ☐Tingling

How is your condition changing? ☐Getting Better ☐ Not Changing ☐ Getting Worse

Today's pain level: No Pain **<** 0------1------2------3------4------5------6------7------8------9------10 **>** Unbearable Pain

In the past week, how much has your pain interfered with your daily activities (work, social, household)?

No interference **<** 0------1------2------3------4------5------6------7------8------9------10 **>** Unable to carry out daily activities

Check all that apply ☐ Pain unrelieved by rest ☐ Pain at night ☐ Dizziness/Fainting ☐ Recent Infection/Fever ☐ Fall with or without injury ☐ Pregnant/ # weeks _____

In general, how is your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐Fair ☐ Poor

Who have you seen for your *current* problem before today? ☐ No-One ☐ Doctor ☐ Chiropractor ☐ Physical Therapist

☐ Acupuncturist ☐ Occupational Therapist ☐ Other: _____

>>>If you are a returning patient, your therapist will review your previous medical history with you. Be sure to discuss all changes in your medical condition with them <<<

CONSENT FOR CARE AND TREATMENT

I, the undersigned, give my consent for "Progress" to furnish medical care and treatment considered necessary and proper in diagnosing or treating patient's physical condition.

PRIVACY NOTICE/ HIPAA

A copy of our Privacy Notice was given to you, which describes how your personal medical information will be used or disclosed. PLEASE REVIEW IT CAREFULLY.

HIPAA allows us to speak with family and friends involved in your care. Is there anyone specific you would like us to list by name? _____

Is there anyone that you do **NOT** want us to speak with? _____

CANCELLATION - Kindly provide at least **24-hours** notice if you are unable to keep an appointment so that we may offer that time to another patient. Missed appointment fees may apply if proper notice is not provided.

Patient/Guardian Signature _____ **Date** _____

Printed Name _____ **PT Initial/date** _____

Medical History Questionnaire

Dba InMotion Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

FAMILY HISTORY

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Chemical Dependency (i.e. Alcoholism)
- ☐ Ehlers-Danlos Syndrome
- ☐ Other
- ☐ Cancer
- ☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)
- ☐ Stroke
- ☐ Depression
- ☐ Osteoporosis

Please check any of the following that apply to you:

- ☐ Pain
- ☐ Numbness/Tingling
- ☐ Osteoarthritis
- ☐ Multiple Sclerosis
- ☐ Asthma
- ☐ Dizziness/Fainting
- ☐ High Blood Pressure
- ☐ Circulation Problems
- ☐ Osteoporosis
- ☐ Epilepsy
- ☐ Emphysema/Bronchitis
- ☐ Recent Fever
- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ Rheumatoid Arthritis
- ☐ Stroke/CVA (Date) _____
- ☐ Tuberculosis
- ☐ Stomach Ulcers
- ☐ Diabetes
- ☐ Ehlers-Danlos Syndrome
- ☐ Other Arthritic Conditions
- ☐ MRSA
- ☐ Hepatitis
- ☐ Depression
- ☐ Alcohol/Drug Dependence
- ☐ Cancer If Yes, describe what kind & treatment _____
- ☐ Heart Problems If Yes, describe what kind & treatment _____
- ☐ Kidney Problems If Yes, describe what kind & treatment _____

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

- ☐ Easy Bruising
- ☐ Nausea/Vomiting
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever/Chills/Sweats
- ☐ Stress at Home or Work
- ☐ Tremors
- ☐ Seizures
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Eye Redness
- ☐ Joint/Muscle Swelling
- ☐ Excessive Bleeding
- ☐ Difficulty Breathing
- ☐ Regular Cough
- ☐ Arm/Leg Swelling
- ☐ Heart Racing in your Chest
- ☐ Difficulty Swallowing
- ☐ Heartburn/Indigestion
- ☐ Constipation/Diarrhea
- ☐ Blood in Stool
- ☐ Blood in Urine
- ☐ Skin Rash
- ☐ Problems Sleeping
- ☐ Sexual Difficulties
- ☐ Urinary Incontinence
- ☐ Problems Urinating
- ☐ Fecal Incontinence

How much caffeinated coffee or other caffeinated beverages do you drink per day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting? _____

Are you now, or have you ever been, a smoker? ☐ Yes ☐ No If Yes, how many packs of cigarettes do you smoke a day? _____

Have you ever taken an anticoagulant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Have you ever taken steroid medications for any reason? ☐ Yes ☐ No

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Are you currently pregnant or think you might be pregnant? If Yes, estimated delivery date? ☐ Yes ☐ No
If Yes, estimated delivery date _____

Medical History Questionnaire

Dba InMotion Physical Therapy, LLC/Progress Rehabilitation Network, LLC ("Progress")

PROCEDURES / SURGERIES: ☐ **NONE** ☐ **BELOW**

DATE	TYPE	DATE	TYPE

CURRENT MEDICATIONS: ☐ **NONE** ☐ **BELOW** ☐ **LIST ATTACHED**

Please list ALL medications that you are **currently** taking **or** attach a copy of your own list. (**Include** prescription, over-the-counter, and vitamin/nutritional supplements). For each medication, list the name, dosage, frequency and route (mouth, inhaler, intravenously, topically, etc).

MEDICATION	DOSE	FREQUENCY	ROUTE

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this provider/practitioner immediately whenever I have changes in my health condition. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed.

Patient/Guardian Signature _____ **Date** _____

Printed Name _____ **PT Initial Review (Date & Initial)** _____

PT Updated (Date & Initial) _____ **PT Updated (Date & Initial)** _____ **PT Updated (Date & Initial)** _____

Dba InMotion Physical Therapy, LLC

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Progress Rehabilitation Network, LLC and its Affiliates (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice that sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 5300 Hickory Park Drive, Suite 110, Glen Allen, VA 23059, Attention: Compliance Officer.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____
   _____

5. I hereby agree that the Practice may send me confidential communications (e.g. appointment reminders, scheduling changes, responses to my inquiries via:

   PLEASE CHECK ALL THAT APPLY:

   ☐ Home phone/voicemail ☐ Work phone/Voicemail ☐ Mobile phone/voicemail

   ☐ Text Message ☐ Email (Address: _____)

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name (Printed)

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

---

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

___ Accepted ___ Denied ___ Not Applicable _Other (explain) _____

Signature of Authorized Practice Representative _____ Date _____

InMotion Physical Therapy, LLC

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name _____ InMotion Physical Therapy Acct # _____

Medicare # (exactly as on Red-White-Blue Government Medicare Card) _____

Please read and respond to each of the following:

1. **Have you had any Home Health Care visits from any Home Health provider in the past 60 days?** Yes or NO

   If yes, please provide the name and phone number of the Home Health Agency:

   Home Health Agency Name: _____

   Home Health Agency Phone Number: _____

2. **Was your illness/injury due to any of the following:** Yes or No If yes, please indicate.

   ☐ Work-Related

   ☐ Automobile Accident

   ☐ Accident on Property (other than your own)
   (Example: store, restaurant, etc.)

3. **If Medicare coverage is due to age or disability, do you have group insurance coverage through another family member's current employer?**

   ☐ Yes – the group insurance will be primary

   ☐ No – Medicare will be primary

4. **Do you have <u>any</u> benefits through TriCare (formerly Champus)?** Yes or No

If you answered yes to questions 2 or 3 there is a second form to be filled out.

Patient's Signature _____ Date _____

Thank You

Dba InMotion Physical Therapy, LLC

Cancellation/ No Show Policy

You and your Physical Therapist will develop a treatment plan to maximize your progress in physical therapy in order to help you achieve your goals as efficiently as possible. In order to accomplish your treatment goals, adherence to that plan and your attendance to all scheduled appointments is essential.

We understand that normal life events may sometimes interfere with your treatment plan. If you need to cancel, please call us at least 24 hours before your appointment so that we can reschedule you as needed, and offer your original appointment time to another patient waiting for an appointment. There will be a $50 missed appointment fee for cancelling an appointment with less than 24 hours notice, or for missing an appointment without notice (No Show).

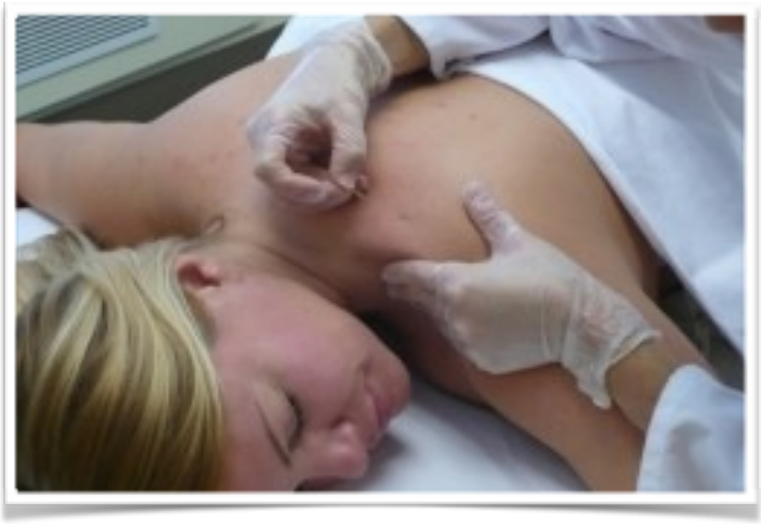
We appreciate your commitment to this process, and your consideration for other patients. If you No Show two (2) appointments, and do not respond to our attempts to contact you, we will interpret that as your decision not to continue therapy. If this occurs, we reserve the right to cancel any a future appointments you may already have on the schedule; and to inform your physician of record that you have discontinued physical therapy.

<u>If you need to cancel or change an appointment, please call us at 804-756-8490 at least 24 hours before your scheduled appointment time.</u>

I have received a copy of this statement and understand this policy.

Patient/Patient's Guardian Signature: _____

Dated: _____



Trigger Point Dry Needling

*"In this age of specialization, few clinicians are broad enough to see the whole patient and his/her problem" Janet G. Travell, MD (1901-1997)

What is Trigger Point Dry Needling (TDN)?

Trigger Point Dry Needling (TDN) is not acupuncture. TDN is a procedure in which a very fine monofilament needle is inserted into the skin and muscle directly at a myofascial trigger point to decrease pain. A myofascial trigger point consists of multiple contraction knots, which are related to the production and maintenance of the pain cycle.

We at Progress Physical Therapy continually seek out advanced continuing education to learn the most cutting-edge and evidence-based techniques to comprehensively treat our patients to achieve the best possible results. TDN is an effective method for treating pain, but not everyone is aware of its use and not all Physical Therapists have completed the required training to perform this procedure.

What is a trigger point?

A trigger point is a small area of muscle that is in spasm (contracted), causing taut bands and hypersensitivity. These "knots" in the muscle cause a restriction of the blood supply which reduces the amount of oxygen, leading to the accumulation of waste products and toxins. This accumulation sensitizes the trigger point, causing it to send out pain signals which increase local and/or referred symptoms. Therefore, a trigger point involves a vicious repeating pain cycle that needs to be broken.

How does TDN work?

The exact mechanisms of dry needling are not known, but there are positive mechanical and biochemical effects which assist in reducing pain. It is essential to elicit a "twitch response" which is a spinal cord reflex and is the first step in breaking the pain cycle.

What type of problems can be treated with TDN?

A variety of musculoskeletal problems can be treated with TDN. Such conditions include, but are not limited to, neck, back and shoulder pain (i.e. frozen shoulder), headaches (including migraines and tension-type headaches), arm pain (i.e. tennis elbow), hip, buttock and leg pain (i.e. sciatic), jaw (TMD) pain, whiplash, carpal tunnel syndrome, and more. The treatment of muscles can have a profound effect on reducing pain mechanisms in the body.

Is TDN painful?

Most patients do not feel the insertion of the needle. The local twitch response elicits a very brief painful response. Some patients compare it to an electric shock; others feel it more like a cramping sensation. The therapeutic response occurs with the elicitation of local twitch responses and that is a good and desirable reaction.

How long does it take for TDN to work?

The time it takes to notice improvement is variable. Typically, it takes several treatment visits for a positive reaction to take place, especially if the condition is chronic. Your Physical Therapist will set up a treatment plan based on your clinical presentation. We are looking for a cumulative response to achieve a certain threshold after which the pain cycle is broken and you begin to experience relief. *Usually, the best results are achieved by combining TDN with other Physical Therapy treatments*.

Do I need a prescription from my Physician?

We want our referring Physicians to know that we are using TDN as a treatment option. You do need a prescription from your Physician to be treated with dry needling. We are happy to discuss this treatment option with your referring Physician if he/she has any questions.

How often do I need to come back to maintain my progress?

The musculoskeletal system is under constant pressure from gravity, stress, work, etc. A regular exercise program, prescribed by your Physical Therapist, which addresses muscle imbalances and maintains normal joint mobility combined with good posture and body mechanics can prevent the recurrence of many problems. If the pain returns, you may need to return for additional TDN and/or progression of other Physical Therapy treatments.

We look forward to serving you in this way at InMotion Physical Therapy!

*Travell, J, Simons, D. Myofascial Pain and Dysfunction: The Trigger Point Manual.Baltimore: Williams & Wilkins; 1983

Dba InMotion Physical Therapy, LLC

Intramuscular Manual Therapy (IMT)
Trigger Point Dry Needling (TDN)
Consent Form

IMT/TDN involves placing a small needle into the muscle at the trigger point which is typically the area which the muscle is tight and may be tender with the intent of causing the muscle to contract then release, improving the flexibility of the muscle therefore decreasing symptoms. The performing therapist will not stimulate any distal or auricular point during the needling treatment.

Dry needling is a focal technique used in physical therapy practice to treat trigger points in muscles. You should understand that this dry needling technique should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist.

IMT/TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as increase muscle performance. Like any treatment there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent.

Risks of the procedure:
Though unlikely there are risks associated with this treatment. The most serious risk associated with IMT/TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may require a chest x-ray and no further treatment as it can be resolved on its own. The symptoms of pain and shortness of breath may last for several days to two weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your IMT/TDN provider. If a pneumothorax is suspected you should seek medical attention from your physician or if necessary go to the emergency room.

Other risks may include bruising, infection, and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a common occurrence and should not be a concern unless you are taking blood thinners. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma for IMT/TDN is unlikely.Please consult with you practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infections that can be transmitted through bodily fluids?

YES NO

If yes, please discuss with your practitioner

Printed Name: _____

Signature: _____ Date: _____

TPDN is not covered by insurance, therefore there is a $50 out of pocket fee for TPDN for one unit (i.e. up to 15 minutes of TPDN). Payment for other Covered procedures also performed during a visit is required. There are three payment options to ensure all procedures performed during a visit are paid.

Please initial the billing option that you choose.

1. Cash plus Insurance: Pay $50 for TPDN at the time of service, and have the remaining covered procedures billed to your insurance. This means that you are also responsible for whatever your insurance requires based on your benefits package (i.e. copay, co-insurance, and payment toward deductible).

   I select Option #1: _____ Date: _____
   Patient's or Representative's Initials

2. Limited Authorization***: Pay $100 for the entire visit, including TPDN, at the time of service. Subsequent visits that do not include TPDN will be billed to your insurance. Since nothing gets billed to your insurance, none of your visits or payments count toward visit limitations, your deductible, or your out of pocket maximum. (Please note: this is based on a 30-minute appointment slot; the cost will be more for longer sessions.

   I select Option #2: _____ Date: _____
   Patient's or Representative's Initials

3. Limited Authorization***: Self-Pay Only***: Convert from Insurance to Self-Pay for your entire course of care: Pay $100 for the entire visit, including TPDN, at the time of service. Since nothing gets billed to your insurance, none of your visits or payments count toward visit limitations, your deductible, or your out of pocket maximum. (Please note: this is based on a 30-minute appointment slot; the cost will be more for longer sessions.

   I select Option #3: _____ Date: _____
   Patient's or Representative's Initials

Staff Signature: _____ Date: _____

PLEASE NOTE: Options #2 and #3 cannot be applied to Medicare or Medicare Replacement Plans