PATIENT INFORMATION			
Full Name (First, MI, Last, Suffix):		SSN:	DOB:
Address:	City:	State:	Zip Code:
Home Phone:	Cell:		Sex: Male Female
Status: ☐ Married ☐ Single ☐ Divorced	Reason for Referral (Diagnosis)		
E-mail Address:	Would you like to receive e-mail appointment reminders? ☐ Yes ☐ No		
How did you hear about us?	Would you like to receive electronic statements? ☐ Yes ☐ No		
Emergency Contact:	Phone:	Relationship:	
Referring Physician:	Primary Care Physician:		
Is this injury related to any of the following (circle one)	Work	Auto Accident	Other N/A
EMPLOYER INFORMATION			
Employer Name:	Occupation:	Work Phone:	
Employer Address:	Work Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐Student		
PRIMARY INSURANCE INFORMATION/POLICY HOLDER INFORMATION			
Primary Insurance:	ID Number:	Group Number:	
Policy Holder Name: (if other than self)	☐ Spouse ☐ Parent ☐ Other	Policy Holder DOB:	
Policy Holder Address: (only if different)	City/State:	Zip Code:	
Policy Holder Phone:	Policy Holder Employer:		
SECONDARY INSURANCE INFORMATION/POLICY HOLDER INFORMATION			
Secondary Insurance:	ID Number:	Group Number:	
Policy Holder Name: (if other than self)	☐ Spouse ☐ Parent ☐ Other	Policy Holder DOB:	
Policy Holder Address: (only if different)	City/State:	Zip Code:	
Policy Holder Phone:	Policy Holder Employer:		
WORKER'S COMPENSATION or AUTO/LIABILITY INFORMATION			
Worker's Comp, Auto Carrier or Attorney Name:	Date of Injury:	Accident State:	
Claim Number:	Contact Name & Phone Number:		
By Signing below, I acknowledge that all of the above information is true and accurate. If at any time any of this information changes, I am aware that I must inform the facility immediately.			
Patient/Guardian:	**Date:**		

Primary Insurance Verification			
Primary Insurance:	ID #:	Group #:	
Co-Pay:	Deductible:	Co-Insurance:	Visits:
Effective Date:	OOPMAX:	Referral Needed:	
Accumulated towards Deductible:	Accumulated towards OOPMAX:	Visits Used:	
Secondary Insurance Verification			
Secondary Insurance:	ID #:	Group #:	
Co-Pay:	Deductible:	Co-Ins:	Visits:
OOPMAX:	Effective Date:	Visits:	
Accumulated towards Deductible:	Accumulated towards OOPMAX:	Visits Used:	
Acknowledgement			
A copy of the patient's insurance ID and photo ID were taken and verified that the identity of the patient is correct.	Staff Signature: ______________________ Date: _________		
A copy of the MSP form has been filled out by the patient and is on file. Any questions that were answered as "yes" by the patient have been reported to the Office Manager or Practice Administrator.	Staff Signature: ______________________ Date: _________		

InMotion Physical Therapy, LLC
An Affiliate of Progress Rehabilitation Network, LLC

CONSENT FOR CARE AGREEMENT

- I, the undersigned, do hereby agree and give my consent for Progress Rehabilitation Network, LLC, d/b/a InMotion Physical Therapy, LLC ("Clinic") to furnish medical care and treatment to,

_________________________________, considered necessary and proper in diagnosing or treating his/her physical condition.
(Name of patient)

ASSIGNMENT OF BENEFITS AGREEMENT

- I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance and third party payers to the Clinic.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient/Guardian ___________________________________ Date ____________

Printed Name: _____________________________________

Relationship to Patient: ______________________________

FINANCIAL POLICY STATEMENT

If you have health care benefits, the Clinic will submit a claim to your insurance company on your behalf and allow no less than 60 days for the insurance company to respond. However, you are required, and you agree, to pay at time of service any required co-payments and deductibles, as well as charges for services not covered by insurance, outstanding balances, and delinquent accounts. For your convenience, we accept cash, checks and credit/debit cards. By signing this document, you acknowledge that your insurance company may determine that the services provided are not covered under your insurance policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay, the cost of any such services. ***Initial*** __________

If you do not have health care benefits, you are required, and you agree, to pay at time of service, all charges as well as any outstanding balances and delinquent accounts. Patients that elect to be "Self Pay" are expected to pay at time of service.

We do not bill insurances for supplies, durable medical goods and equipment, and certain cash-based services (massage therapy, exercise classes, independent exercise, bike fitting, etc. You will be billed directly for these goods and/or services.

If you pay by check, and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee of $50 within 30 days of the returned check. ***Initial***_________

I acknowledge that balances older than 90 days may be assessed an 18% annual percentage rate (APR) finance charge (1.50% per month).
If any debt is owed to the Clinic and is referred to an attorney or collection agency for collections, I agree to pay all attorney and collection fees in the amount of thirty-three percent (33%) of the total indebtedness, including all court costs and filing fees incurred by the Clinic. I understand and agree that should the Clinic be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1.50%) per month or eighteen percent (18%) per annum, beginning on the date of judgment. ***Initial*** _________

Under the assignment of benefits agreement above, if any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to the Clinic. ***Initial***_________

☐ **Insurance**
We do our best to verify your plan benefits with your insurance company as a courtesy to you. However, benefits that we are quoted by your insurance company are not a guarantee of payment. Actual benefits are determined by your insurance company at the time the claim is processed. Co-pays will be collected at the time services are rendered. When payment from your insurance company is received, we will know then if we have to modify your co-pay. If you have a co-insurance, a deductible, or any other "Patient Responsibility" as determined by your insurance company, a bill will be sent to you with payment due upon receipt.

☐ **Worker's Compensation**
The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for, and expected to pay, the total amount of charges for services rendered to you.

☐ **Cancellation/No Show Policy**
If you need to cancel an appointment, kindly provide at least 24 hours notice so that we may offer that time to another patient. Failure to provide 24 hours notice of need to cancel an appointment, or failing to appear for a scheduled appointment (No Show) will result in a $50 charge.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY STATEMENT

Guarantor: ____ Date ________________________________

Guarantor Printed Name: _________________________________ Relationship to patient ____________________

Progress Rehabilitation Network, LLC
All Rights Reserved

Dba InMotion Physical Therapy, LLC

Medical History Questionnaire

To assist your therapist in completing a thorough evaluation, please provide us with all medical background information. If you do not understand a question, please leave it blank and your therapist will assist you.

Name: ____

Occupation: ____

Leisure Activities: ____

ALLERGIES: List any medications you are allergic to: _______________________________________

Are you latex sensitive? ☐ Yes ☐ No List any other allergies we should know about: ________________

____

Please check any of the following whose care you are under:

☐ Medical Doctor (MD)
☐ Osteopath
☐ Dentist
☐ Psychiatrist/Psychologist
☐ Physical Therapist
☐ Chiropractor
☐ Other: ____________________
____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, routine physical, etc.):

____

____

Check if you have **EVER** been diagnosed as having any of the following conditions?

☐ Blood Clots
☐ High Blood Pressure
☐ Circulation Problems
☐ Asthma
☐ Chemical Dependency (i.e. Alcoholism, Prescription Medication)
☐ Diabetes
☐ Multiple Sclerosis
☐ High Cholesterol
☐ MRSA
☐ Rheumatoid Arthritis
☐ Thyroid Problems
☐ Cancer If Yes, describe what kind & treatment ______________________________
☐ Heart Problems If Yes, describe what kind & treatment ______________________________
☐ Kidney Disease If Yes, describe what kind & treatment ______________________________

☐ Tuberculosis
☐ Stroke
☐ Stomach Ulcers
☐ Emphysema/Bronchitis
☐ Epilepsy
☐ Depression
☐ Ehlers-Danlos Syndrome
☐ Hepatitis
☐ Other Arthritic conditions
☐ Osteoporosis

Other ____

Do you have a pacemaker? ☐ 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? Estimated Delivery Date? __________ ☐ Yes ☐No

Dba InMotion Physical Therapy, LLC

Medical History Questionnaire

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
☐ Cancer
☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)
☐ Stroke
☐ Depression
☐ Osteoporosis

Please list all surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

	Date	Reason for Surgery/Hospitalization		Date	Reason for Surgery/Hospitalization
1.	_______	______________________________	4.	_______	______________________________
2.	_______	______________________________	5.	_______	______________________________
3.	_______	______________________________	6.	_______	______________________________

Please describe all significant injuries for which you have been treated (including fractures, dislocations, sprains/strains) and the approximate date of injury.

Injury	Date	Injury	Date
1) ______________________________	__________	2) ______________________________	__________
3) ______________________________	__________	4) ______________________________	__________
5) ______________________________	__________	6) ______________________________	__________

How much caffeinated coffee or other caffeinated beverage do you drink per day? ___________
How many packs of cigarettes do you smoke a day? _________
How many days per week do you drink alcohol? ____________
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _________
Have you ever taken steroid medications for any reason? _____________
Have you ever taken an anticoagulant? ______________

OTHER CONDITIONS

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

☐ Weight Loss
☐ Weight Gain
☐ Nausea/Vomiting
☐ Fatigue
☐ Weakness
☐ Fever/Chills/Sweats
☐ Numbness or Tingling
☐ Tremors
☐ Seizures
☐ Double Vision
☐ Loss of Vision
☐ Eye Redness
☐ Skin Rash
☐ Problems Sleeping
☐ Sexual Difficulties
☐ Night Sweats
☐ Easy Bruising
☐ Joint/Muscle Swelling
☐ Dizziness/Lightheadedness
☐ Excessive Bleeding
☐ Difficulty Breathing
☐ Regular Cough
☐ Arm/Leg Swelling
☐ Heart Racing in your Chest
☐ Difficulty Swallowing
☐ Heartburn/Indigestion
☐ Constipation/Diarrhea
☐ Blood in Stool
☐ Post Menopause
☐ Problems Urinating (difficulty starting, painful, etc.)
☐ Urinary Incontinence
☐ Blood in Urine
☐ Hearing Problems
☐ Stress at Home or Work

Dba InMotion Physical Therapy, LLC

Medical History Questionnaire

MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc). You may attach a copy of your own list of medications if available.

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

During the course of your Physical Therapy, if there are *__any changes__* (type or dosage) in your medications or supplements, it is important that you notify your therapist!

Patient Signature: ____________________________________ Date: ______________________

Reviewed with Patient: ________________________________ Date: ______________________

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 which 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): ____
   ____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

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

____
Date of Birth

____
Social Security Number

______________________________ ______________
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

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).

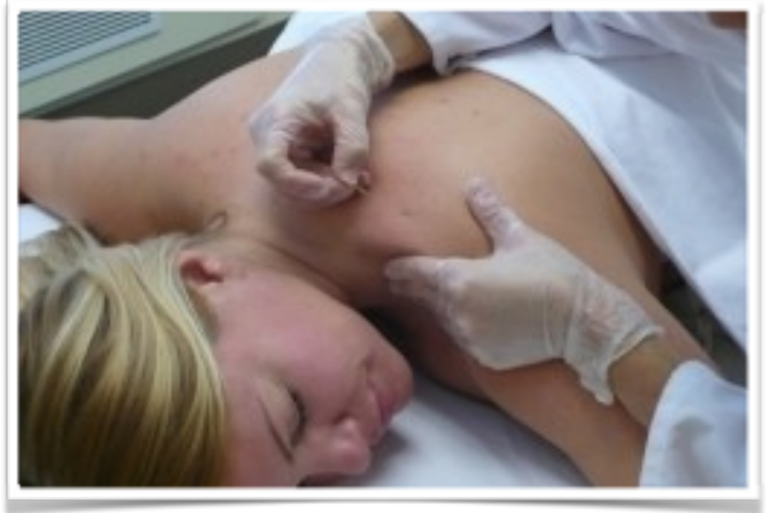
We appreciate your commitment to this process, and your consideration for other patients. If you No Show two (2) appointments, and do not respond to our attempts to contact you, we will interpret that as your decision not to continue therapy. If this occurs, we reserve the right to cancel any a future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

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.

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

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

Please print your name ____________________

Signature ____________________ Date __________