GUIDELINES AND POLICIES FOR PHYSICAL THERAPY PATIENTS

- When you arrive for therapy, please be seated. Your therapist will call you back.
- Please be prompt! Our therapists strive to make your wait time less than 5 minutes from your appointment time. Please show them and other patients the same courtesy. If you are more than 15 minutes late, we will need to reschedule your appointment.
- If you show 30 minutes before your scheduled appointment time and we are busy you may have to wait until your scheduled time as other patients have appointments also.
- Please be prepared to PAY YOUR CO-PAY OR CO-INSURANCE AT EACH VISIT. If you have questions about your insurance please review your insurance policy, or we can help you with clarification.
- Patients under the age of 18 must be accompanied by a parent or legal guardian.
- For our patients with young children: Due to insurance liabilities we cannot allow children in the gym. Please make arrangements for them while you are attending your appointments.
- **Office hours**: By appointment only, Monday thru Friday. If you call during non-office hours, you may leave a voice message.

CANCELLATION/ NO-SHOW POLICY

- If you need to cancel or reschedule your appointment for any reason, we require 24 hours notice (except extenuating circumstance), as we are holding a spot for you in our schedule that other patients could use. Failure to contact our office to cancel your appointment less than 24 hours prior to your appointment will result in a less than 24 hour cancellation charge to you.
- No-Shows (not showing up for your appointment with no phone call to the office or therapist) are not acceptable as your therapist has blocked one-on-one time for your care. No-showing for your appointment will result in a No-Show charge to you.
- Preferred method to be contacted by our staff regarding upcoming appointments (please check one):

Phone Call: ❒	Text Message: ❒
Phone Number:	

We look forward to working with you.

Nichole King, DPT
Physical Therapist/Clinic Director

I have read or had this information explained to me to my satisfaction, and I agree to comply with all clinic guidelines and the Cancellation/No- Show Policy.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

BestLife Physical Therapy AND SPORTS MEDICINE

PATIENT REGISTRATION

A.Patient Information			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	ZIP:
Email:	DOB:	SSN:	
Home Phone:	Cell Phone:	Work Phone:	
Physician Name:	Date of Last Appt:	Phone Number:	
Are you a Student? ❒ YES ❒ NO: If YES, what school do you attend?		Grade Level:	
Please share how you were referred to Best Life?			

B. Emergency Contact Information		
First Name:	Middle Initial:	Last Name:
Relation to Patient: ❒ Spouse ❒ Parent ❒ Friend ❒ Other:		Phone Number:

C. Parent/Guardian Information (only fill out if patient is a minor)			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	ZIP:
Relation to Patient:	DOB:	SSN:	
Home Phone:	Cell Phone:	Work Phone:	

D. Employer Information			
Name of Employer:		Occupation:	
Address:	City:	State:	ZIP:

E. Insurance Information: Will we be billing insurance? ❒ YES (please provide Insurance Card) ❒ NO			
Name of Primary Insurance Carrier:	Policy #:	Group #:	
Subscriber (Insured) Information: **Check Here** ❒ if Name, Address, Employer, DOB, and SSN, are same as patient			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	ZIP:
Employer:	DOB:	SSN:	
Name of Secondary Insurance Carrier:	Policy #:	Group#	
Subscriber (Insured) Information: **Check Here** ❒ if Name, Address, Employer, DOB, and SSN, are same as patient			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	ZIP:
Employer:	DOB:	SSN:	

BestLife Physical Therapy AND SPORTS MEDICINE

Dedicated to helping you live your best life.

MEDICAL HISTORY

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you!

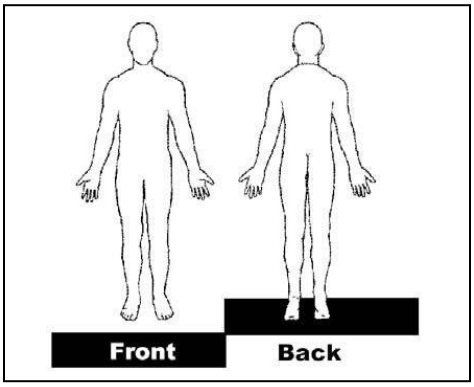
Do you have or have you had any of the following:

Cancer	❒ YES ❒ NO
Diabetes	❒ YES ❒ NO
Epilepsy	❒ YES ❒ NO
Heart Disease	❒ YES ❒ NO
High Blood Pressure	❒ YES ❒ NO
Metal Implants	❒ YES ❒ NO
Respiratory Problems	❒ YES ❒ NO
Psychological Problems	❒ YES ❒ NO
Are you Pregnant?	❒ YES ❒ NO
Do you have Allergies?	❒ YES ❒ NO

If yes, what _____

Please describe why you are seeking physical therapy at this time. Include any additional history on your current pain symptoms, including date of injury, if applicable:

On the diagram to the right, please use an "X" to mark areas of pain. Use a larger "X" for the most painful area.



Current Medications: _____

Surgeries (What/Where/When): _____

Recent Illness (What/When): _____

Work Related Injury	
Were you injured at work? ❒ YES ❒ NO	Date of Injury (mm/dd/yy):
Name of Compensation Carrier:	Claim #:
Address:	
Auto Related Injury	
Were you injured in a traffic accident? ❒ YES ❒ NO	Date of Accident (mm/dd/yy):
Name of Auto Insurance Carrier:	Ins. Co Phone Number:
Policy #:	Claim #:
Address:	

BestLife Physical Therapy AND SPORTS MEDICINE

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

DATE: _____

PATIENT: _____

PATIENT DOB: _____

PATIENT PHONE NUMBER: _____

PERSON/DOCTOR(S) WE MAY DISCUSS YOUR SCHEDULE OR CARE WITH

NAME(S): _____

WORKER'S COMP PATIENTS

_____ here by authorizes the release of protected health information such as number of cancelations and no show appointments resulting in non-compliance of therapy to my case manager _____ (name of person or referring provider) and any or all notes or bills pertaining to the payment of my treatment or continued care at another facility.

PROVIDER NAME/FACILITY: **Best Life Physical Therapy and Sports Medicine**

ADDRESS: **2404 Potters Rd. Suite 400**

CITY/STATE/ZIP: **Virginia Beach, VA 23454**

PHONE NUMBER: **(757) 961-5888**

FAX NUMBER: **(757) 340-6210**

By signing this authorization, I understand that I or the above signed, have the right to receive a copy of my records upon written request; anyone seeking information regarding my treatment at this facility has permission. You as the patient will be notified of any such person wanting information pertaining to your therapy with this office. This authorization is valid for one year from date of signature, unless otherwise revoked in writing. A copy of this authorization gives the same rights and permissions as the original.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

CONSENT FOR CARE AND PRIVACY PRACTICES ***TWO SIGNATURES REQUIRED***

CONSENT FOR CARE AND TREATMENT

I understand and agree that I am responsible to make payments on my account and if I fail to make any of the payments for which I am responsible in a timely manner, that I am responsible for interest as well as for all collection costs including but not limited to court costs, collection agency fees, and attorney fees.

I, the undersigned, do hereby agree and give my consent for Best Life Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

*****SIGNATURE REQUIRED BELOW****

Patient/Guardian Signature:_____ DATE: _____

CONSENT TO TREATMENT OF A CHILD *(only fill out if patient is a minor)*

I hereby authorize Best Life Physical Therapy Physical Therapists and whoever they may designate as assistants to administer treatment to my son/daughter (circle one), _____ as they deem necessary and appropriate.

Signed: _____ DATE: _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the "HIPPA Notice of Privacy Practices" for Best Life Physical Therapy and Sports Medicine. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law, I must give my written authorization to Best Life Physical Therapy and Sports Medicine to release any of my protected healthcare information.

My signature below acknowledges that I have read this document and understand the responsibilities I am expected to uphold, and understand my rights as described herein.

*****SIGNATURE REQUIRED BELOW****

Patient/Guardian Signature: _____

DATE: _____ Patient/Guardian Printed Name: _____

BestLife Physical Therapy AND SPORTS MEDICINE

2404 POTTERS RD. SUITE 400
VIRGINIA BEACH, VA 23454
PHONE: 757-961-5888
FAX: 757-340-6210
BESTLIFEPHYSICALTHERAPYVB@GMAIL.COM

Patient Information and Consent for Dry Needling as a Procedure for the Assessment and Treatment of Myofascial Trigger Points and Tender Points

Myofascial trigger points and tender points which appear in soft tissue, and are painful sites, reflect abnormal nervous system activity associated with many neuro-musculoskeletal conditions that are treated in our office. The procedure known as Dry Needling is an important tool for diagnosing, treating and monitoring changes in myofascial trigger/tender points. During this procedure, a sterile, very thin, solid filament needle is inserted into tissue that may be associated with one or a number of your complaints. One or a number of needles may be used, and the procedure may be performed during more than one office visit. The number of needles, and the frequency of the procedure will depend entirely on your condition at each office visit. There is little to no pain with this procedure. There is little to no bleeding with this procedure. While an infection is an unlikely event with this procedure, whenever there is penetration of the skin, there is the risk of infection. Other unlikely but possible events include fainting, soreness, or pneumothorax (lung puncture). If you have a fear of needles, a genetic bleeding disorder, a history of a blood disorder that can be transmitted to another person, are regularly taking any blood thinning medication (for example, Coumadin or Warfarin), or are regularly taking any pain relievers containing ibuprofen, NSAIDS, aspirin or acetaminophen (for example, Tylenol, Advil, Aleve, or Bufferin), please inform us by placing a check mark as indicated below:

_____ I have a fear of needles.

_____ I have a genetic bleeding disorder. Please specify:
_____

_____ I have a history of a blood disorder that can be transmitted to another person. Please specify:
_____

_____ I am regularly taking blood thinning (anti-coagulation) medication. Please specify:
_____

_____ I am regularly taking pain relievers. Please specify:
_____

I have read this Patient Information and Consent carefully, I understand this procedure is not acupuncture and I have had an opportunity to ask questions and obtain any desired clarification, and I consent to having the procedure of Dry Needling performed on me. I give permission to have the treated region(s) photographed for records/educational purposes

.
Print Name: _____

Signature:_____

Date:_____
If patient is less than 18 years of age, parent or legal guardian must sign below.

Print Name: _____

Signature: _____

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Physical Therapy
AND SPORTS MEDICINE

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Post Dry Needling Treatment
Instructions

After your treatment you could feel a number of different ways and have a variety of reactions that are typical and that should not alarm you. Below you will find the more common effects associated with Dry Needling Treatment.

1. You may feel very tired for a few hours, you should always drink water after treatment to help flush any metabolic “junk” that occurs with manual therapies out of your system.

2. You could also feel very energized and euphoric, that is generally appreciated. Do not overdo it however as your body may need some time to fully recover.

3. You could develop a bruise, while not always pretty, do not be alarmed, but do report it to the doctor.

4. You may see reddened areas or feel a raised or lumpy reaction, this will typically pass within a few hours or by the next day, and these are typical tissue reactions that are of no concern.

5. You could feel sore in the area of treatment for up to 24 hours, take a hot shower and then apply ice. Feeling sore or dull ache is very typical.

6. You may feel a temporary increase in your symptoms but will often improve the next day.

7. Report any and all of your reactions to the doctor whether good or bad.

_____ _____

Patient Signature Date