Release
PHYSICAL THERAPY

Office Policies & Patient Authorization

Release Physical Therapy, PLLC ("Release") hands-on, boutique physical therapy office that provides the best in comprehensive, evidence-based treatments and personalized care. Your treatment is based on ongoing assessments from our therapists during one-on-one, hour-long sessions. Your therapist will plan, implement, and monitor your treatment program based on continuing education and proven care methods.

Prescriptions

In Washington, DC a prescription is not required for physical therapy due to direct access. However, your insurance provider may require a prescription for coverage and payment according to your insurance plan. If this is the case, it is your responsibility to acquire and provide a written prescription during your initial examination.

Appointments

Each physical therapy session is one-on-one and lasts 60 minutes. Your initial evaluation will be approximately 15 minutes of your first session, and you will begin treatment on the same day. In the event that you are not able to keep your appointment, Release requires a minimum of 24 hours notice. **Appointments that are cancelled with less than 24 hours notice will incur a $150 charge not reimbursable by insurance companies.**

Billing/Payment

Payment is collected on the day service is rendered and is solely the responsibility of the patient. As a courtesy, Release will submit and file out-of-network claims on your behalf with your insurance carrier, and your insurance will reimburse you directly. It is your responsibility to ensure that claims are properly processed. As an out-of-network provider, you accept responsibility for all costs not covered by insurance. Release has a relationship with you, and not your insurance company.

Acknowledgment

I have read and understood the above policies and agree to abide by all terms within. I authorize Release to use my protected medical records for submission of claims to my primary insurance. I understand that I am personally responsible for all charges not covered by my insurance.

_____ _____

Name Date

_____

Signature

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We would like to welcome you to Release Physical Therapy. Thank you for selecting our practice. We are committed to provide you with the best possible physical therapy services. Please complete the following information by printing neatly:

Date:_____/_____/_____

Name:_____ DOB: _____/_____/_____
Last, First, Middle

Sex: ☐ Female ☐ Male

email (required): _____

Home Phone:_____ Work Phone:_____ Cell phone:_____

Address: _____
Street city state zip code

Employment: ☐ Employed ☐ Student ☐ Unemployed ☐ Retired ☐ Homemaker

Employer Name:_____

Reason for today's visit:_____

Who referred you to Release Physical Therapy? _____

Insurance Information

Name of Insured:_____ DOB of Insured: _____/_____/_____

Insurance Company Name: _____

Insurance Phone Number: _____

Secondary Carrier (*if applicable*):_____

Were you hurt at work? ☐ No ☐ Yes Date of injury: _____/_____/_____

Have you filed a claim? ☐ No ☐ Yes

Were you hurt in an auto accident? ☐ No ☐ Yes Date of accident: _____/_____/_____

Have you filed a claim? ☐ No ☐ Yes

_____ _____
Signature Date

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Please describe your reason for seeking care:

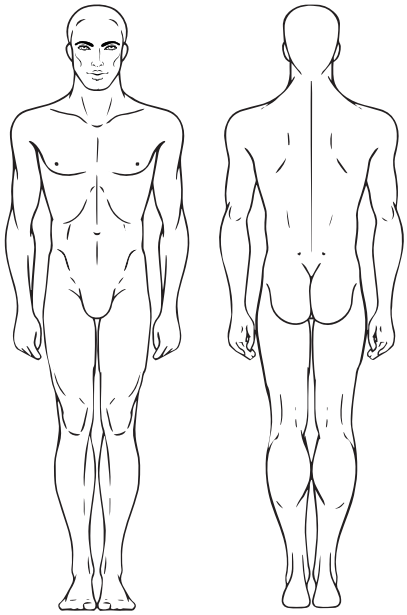
Please describe your level of pain. "0"No pain to "10" Severe Pain

What aggravates your symptoms?

What relieves your symptoms?

What sleeping positions are the least comfortable

What functional activities are the most difficult



Please mark areas where pain exists.

Are you generally in good health? ☐ Yes ☐ No

Have you had any recent surgeries or hospitilizations? ☐ Yes ☐ No
If yes please specify

Are you currently taking any medications? *Please include all over-the-counter medications and vitamins.*

Have you ever taken a steroid? Example Cortisone, Prednisone. ☐ Yes ☐ No

Have you had any recent test such as blood work, X-ray or MRI? ☐ Yes ☐ No

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Name of primary care physician: _____

Are you currently seeing any other medical professionals? _____

Do you have, or have you ever been diagnosed as having, any of the following?

☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Rheumatoid Arthritis
☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Depression
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Chemical Dependency	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Kidney Disease
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Anemia
☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Epilepsy

☐ Yes ☐ No Cancer if yes, please describe

☐ Yes ☐ No Other, If yes, please describe

☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Do you experience and numbness in tingling in your genital area?
☐ Yes ☐ No Have you recently gained or lost more than ten pounds?
☐ Yes ☐ No Are you experiencing any bowel and bladder irregularities?
☐ Yes ☐ No Do you experience weakness in your legs or balance problems?
☐ Yes ☐ No Do you experience blurred vision, nausea, or difficulty breathing?
☐ Yes ☐ No Have you had at least two or more falls in the past year?

I hereby certify that I have completely represented the state of my current health, such as it may be, to the best of my ability. I also understand that omitting information regarding my health may affect the course of treatment. I agree to allow Release Physical Therapy to examine me.

_____ _____
Signature Date

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Release Physical Therapy, may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Release Physical therapy Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Release Physical Therapy, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, at 1170 22nd street Washington, DC 20037.

By signing this form, I consent, Release Physical Therapy, may call my home or other designed location and leave a message on voice mail or disclose to a third party (who may answer my phone) any information that assist Release Physical Therapy in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. I authorize Release Physical Therapy to use an automated telephone system (Phone Tree) to leave a reminder message on my voicemail system or answering machine.

With my consent, Release Physical Therapy, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

I have the right to request that Release Physical Therapy restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this for, I am consenting to allow Release Physical Therapy to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lifespan Family Healthcare, LLC may decline to provide treatment to me.

_____	_____	_____
Patient's Name, (Please Print)	Signature of Patient or Legal Guardian	Date
_____	_____	_____
Legal Guardian's Name, (Please Print)	Relationship to Patient	Date

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Patient Disclaimer and Release Of Liability

I, the undersigned patient, in receiving care, treatment and other servlces from **Release Physical Therapy PLLC** ("Provider") located at the Club facility known as Equinox Washington LLC d/b/a Equinox - Washington D.C. at 1170 22nd Street N.W., Washington, D.C. 20037 (the "Club"), hereby acknowledge that the relationship between the Club and Provider is strictly that of landlord and tenant, respectively. I further ackowledge that neither the Club nor any person or entity affiliated with the Club has any responsibility or liability for any injuries, claims or damages arising from any treatment or other services performed by Provider.

In addition, I understand that I might have access to use certain areas of the Club under the direction of the Provider and agree to the following:

l. Assumption of Risk. I understand that engaging in physical exercise includes an inherent risk of minor or major life threatening injury to persons and property, and death, including. but not limited to injury arising from or relating to your participation in any supervised or unsupervised personal training or instruction conducted in or outside the Club. I hereby expressly agree to assume full responsibility for all bodily injury, death, property damage, and theft or loss of personal property, that might result from my use of the Club, equipment, services, programs, and personal training or instruction, no matter what causes such injury, damage or loss, including the active or passive negligence of the Club, its employees, agents, or independent contractors.

2. Waiver and Release of Liability. By my execution of this Agreement, I hereby waive any claims or rights that I may have hereafter against Equinox Sports Club, the Club an its and their respective owners, affiliates, officers, directors, employees,independent contractors and agents (collectively, the "releasees") and agree to release and hold the releasees absolutely harmless from any and all claims, demands, injuries (including death), damages, losses, liabilities, actions, suits, or causes of action to persons or property, present and future arising from or related to my use of the Club, includmg the equipment, services programs, and personal training or instruction conducted inside or outside the Club, whether caused by the negligence of the releasees, except as to such claims which may arise from the gross negligence or willful misconduct of the releasees. I acknowledge that I have carefully read this Waiver and Release of liability and fully understand it is a release of liability.

_____	_____	_____
Patient's Name, (Please Print)	Signature of Patient or Legal Guardian	Date
_____	_____	_____
Legal Guardian's Name, (Please Print)	Relationship to Patient	Date

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Covenant and Financial Agreement

I AGREE TO THE FOLLOWING TERMS WITH REGARDS TO THE MANAGEMENT OF MY HEALTHCARE WHILE RECEIVING TREATMENT AT RELEASE PHYSICAL THERAPY

1. I will be truthful regarding my condition, and neither falsely exaggerate not minimize my complaints. Doing so may affect the course and results of my treatment.

2. I am responsible for my own healthcare, and though my decisions may be guided by the therapists here, I have the greatest control regarding my treatment. I have the right to refuse services and/or treatments, and my decisions with be respected.

3. I agree to undergo periodic re-evaluations to monitor my progress and changes in symptoms.

4. I will be informed regarding the risks and benefits of the treatments, and expected time frame of improvements.

I THE PATIENT AGREE TO PAY TO THE ORDER OF RELEASE PHYSICAL THERAPY FOR SERVICES RENDERED AT THE TIME OF CARE. Release Physical Therapy is out of network and I am responsible for all deductibles, co-insurance, and non-covered services.

I the patient will pay to the order of Release Physical therapy any cancellation charges for missed appointment without 24 hours advanced notice. I acknowledge that cancellation charges are 120 per missed appointment and that future appointments will not be made until any and all cancellation charges have been paid in full.

We have read and understand the above and affix our signature:

_____ _____

Signature Date

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Intramuscular Manual Therapy aka Functional Dry Needling (FDN) Consent Form

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

IMT / FDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint paint, as well as to 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 to treatment.

Risks of the procedure:

Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to 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 pneumo 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 blood 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 a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT / TDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily Fluids? ☐ **YES** ☐ **NO**

If you marked yes, please briefly explain and discuss with your practitioner.

_____ _____

Signature Date

_____

Name, Please Print