FUNCTIONAL PERFORMANCE CENTER

Personal Information

First name:		Last name:	DOB:
Street Address:			Apt:
City:	State:	Zip:	
Phone number		Social Security Number:	
Email:			
Appointment Reminder *(please circle one)*: Email Text Phone None			

Insured Party/Responsible Party *(Leave blank if same as patient)*

First Name:		Last Name:	DOB:
Street Address:			Apt:
City:	State:	Zip:	
Phone Number:		Social Security Number:	
Email:			
Appointment Reminder *(please circle one)*: Email Text Phone None			

Insurance Information

Insurance Provider:	
Group number:	Member number:
Primary Care Physician:	
Referring Physician *(if different*):	
How did you hear about us?	

Emergency contact information

First Name:	Last Name:
Relationship:	Phone number:

I certify that all the information above is true and correct

Print Name: _____ Date: _____

Signature/Guardian: _____

FUNCTIONAL PERFORMANCE CENTER

PATIENT AUTHORIZATION

- **Release of Information & Consent for Treatment**

  I am aware of my diagnosis and wish to receive treatment at Functional Performance Center. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

  I give permission to the Functional Performance Center to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, case manager, employer, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided.

  I authorize the Functional Performance Center to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

- **Assignment of Benefits**

  I authorize payment directly to Functional Performance Center for services and to bill and release payment directly to Functional Performance Center for any rehabilitative/physical medicine services provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

- **Notice of Privacy Practices (HIPAA Acknowledgment / Consent)**

  I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for the Functional Performance Center. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

When you must cancel, please give us at least 24 hours notice to avoid a fee. We are rarely able to fill a cancelled session unless we know at least 24 hours in advance.

If you are unable to contact our office the day before your scheduled appointment during regular business hours, you will be charged a $20.00 fee.

If you do not contact our office and you miss the scheduled appointment, a $50.00 fee will be charged to your account.

You should note that insurance companies do not typically reimburse for missed appointments.

The only time we will waive this fee is in the event of serious or contagious illness or emergency.

The signature below certifies that I have read and understand the above information.

Print Name: _____ **Date:** _____

Signature/Guardian: _____

Payment Guarantee

We participate with most local and many national insurance plans. However it is your sole responsibility to understand whether your insurance has limits on the providers you can see, and/or the services you can receive. When you provide complete and accurate insurance information, we will submit claims to your insurance carrier and receive payments for services.

Depending on your insurance coverage, you may be responsible for co-payments, co-insurance, or deductible(s).

FUNCTIONAL PERFORMANCE CENTER PAYMENT POLICY
We are doing everything possible to keep the cost of care affordable. You can help a great deal by abiding by the following policies.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE
Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes: deductibles, coinsurance and copayments for participating insurance companies. We gladly accept Visa, Master Card, Discover, Personal Checks, Cash.

Accounts with an outstanding balance 60 days or more must make arrangements for payment prior to scheduling appointments.

INSURANCE
We bill participating insurance companies as a courtesy to you. You are expected to pay your copayments at the time of service. If you need assistance or have questions, please contact the Billing Manager at 303-948-1868 extension 2 weekdays between 9a.m. and 5p.m.

REFERRALS
Your rehabilitative/physical medicine care is best handled by a partnership between you and your physician. Receiving a referral from your doctor guarantees this. Retroactive referrals are not guaranteed. Payments for services provided by specialists are determined by your insurance company.

I have read and understand the FUNCTIONAL PERFORMANCE CENTER Financial Policy. I agree to assign insurance benefits to FUNCTIONAL PERFORMANCE CENTER whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

If you are receiving Chiropractic care simultaneously with rehabilitative/physical medicine we recommend receiving these services on different days as insurance could deny for services rendered on the same day, leaving you as the patient responsible for charges at 100% of billed amounts.

Print Name: _____ Date: _____

Signature/Guardian: _____

Dry Needling Consent Form

Dry needling is a valuable adjunct treatment for chronic pain, stiffness and to deactivate myofascial trigger points. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure.
With the dry needling technique, a fine, flexible and sterile acupuncture needle is used. The purpose of the needling is to release shortened bands of muscle caused by abnormal functioning of the nervous system. No drugs are injected.

Dry needling may cause an increase in pain for one to three days followed by an expected improvement in the overall pain state. The increased pain is related to overactive shortened muscle bands that have not been released and to the soreness caused by the "twitching" of the muscles.
Any time a needle is used there is risk of infection. However, we are using new, disposable and sterile needles, and infections are extremely rare. A needle may be placed inadvertently in an artery or vein. If an artery or vein is punctured with the needle, a hematoma (or bruise) will develop. If a nerve is touched, it may cause paresthesia (a prickling sensation) which is usually brief, but may continue for a couple of days. When a needle is placed close to the chest wall, there is a rare possibility or pneumothorax (air in the chest cavity).

Fortunately, all these complications are not fatal and are readily reversible. A gown is provided for female patients. However for proper and thorough examination and treatment, the gown may be opened up from the back or it may be partially moved by the practitioner. Care will always be taken to respect your privacy. Patients are requested to inform practitioners about conditions such as pregnancy, pacemakers, and the use of blood thinners or immunosuppressant medications prior to the treatment.

*****PATIENTS USING INSURANCE FOR THEIR CARE: Please note that there will be a $20 supply cost for this treatment*****
*****DUE AT TIME OF APPOINTMENT*****

I have read or had read to me the above; I understand the risks involved with dry needling. I have had the opportunity to ask any questions I had and all of my questions have been answered. I consent to examination, treatment and payment at Functional Performance Center, including dry needling.

Print Name: _____ Date: _____

Signature/Guardian: _____

FUNCTIONAL PERFORMANCE CENTER

Patient Name: _____ **DOB:** _____

Occupation:_____ **New Patient:** □ Yes □ No **Referring Physician:** _____

Injury / location: _____ **Cause:** _____ **Date of Injury/Onset:**_____

Rate your symptoms / pain: (circle one) 0 1 2 3 4 5 6 7 8 9 10
None *Worst imaginable*

How often do you have symptoms? (circle one) Intermittently Occasionally Frequently Constantly

Medications:_____

Vitamin/Supplements: _____

Past Medical History	**YES**	**NO**		**YES**	**NO**
High or Low Blood Pressure	□	□	Fracture / Broken Bones	□	□
Heart / Vascular Problems	□	□	Neuromuscular Disease	□	□
Diabetes: Type I or Type II	□	□	Dizziness / Blackouts	□	□
Lung / Respiratory Problems	□	□	Headache / Migraine	□	□
Cancer	□	□	History of Abuse	□	□
Bladder / Bowel Disorder	□	□	Stroke / CVA	□	□
Seizures	□	□	Allergy to Latex	□	□
Arthritis	□	□	Allergy to Adhesives	□	□
Autoimmune Disorders	□	□			

Pregnancies # _____ Natural #_____ Caesarian #_____

Surgical History	**YES**	**NO**	**Date**	**Please Describe**
Orthopedic Surgery	□	□		
Joint Replacements	□	□		
Heart Surgery	□	□		
Spinal Surgery	□	□		
Gastrointestinal Surgery	□	□		

Other Surgeries:_____

Please list any current limitations/restrictions:

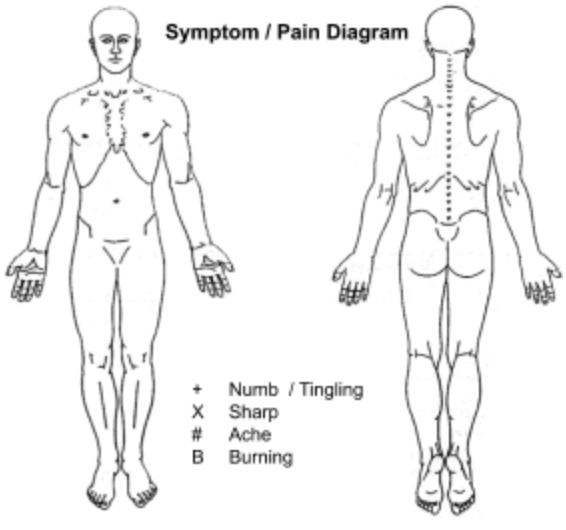
_____

Have you fallen in the past year?
□ Yes □ No

If yes, did any fall in the past year result in injury?
□ Yes □ No
If Yes please list date: _____

Have you received Physical Therapy for this injury before?
□ Yes □ No
If Yes please list date: _____

Have you received Chiropractic Services for this injury before?
□ Yes □ No
If Yes please list date: _____



COVID-19: Staying Safe In The Clinic

Due to ongoing Covid-19 concerns and precautions we want to make you aware of how we are keeping everyone safe in our clinic:

- Please stay comfortably in your car until the time of your appointment to avoid overlap. If you arrive in the clinic early, you will be asked to wait outside until your appointment time.
- We are limiting the number of people in the clinic to only the therapist, their patient, and a front desk staff person: family and friends must wait in the car.
- When you arrive you will:
    - Wear a face mask. You may use your own or we will supply you with one if you forget yours or do not have one.
    - Use available hand sanitizer or wash your hands
    - Have your temperature read by a forehead thermometer (which is sanitized after every use)
    - Be asked about symptoms consistent with COVID-19 in the past 14 days

  If your temperature is greater than 100 °F or you have symptoms consistent with COVID-19 in the past 14 days, your in-person appointment will be cancelled and transitioned to a telehealth appointment.
- Equipment is thoroughly cleaned after each use. This includes any exam tables, resistance bands, weights, instruments, linens, etc.

_____ I have read, understand, and agree with the procedures outlined above
Initial

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled. Charges will be for copays, supplies, billing, and late cancellation fees.

Credit Card Information
Card Type: □ MasterCard □ VISA □ Discover □ AMEX □ Other
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):
Card Security Code:

I,_____, authorize Functional Performance Physical Therapy Center, PLLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature *Date*