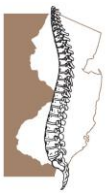


Spine & Orthopaedic Physical Therapy Center of NJ

PATIENT ADMISSION FORM

Patient name: _____

Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phones: Cell: _____
Home: _____
Work: _____

Male: ___ Female: ___ Marital status: _____ Date of birth: _____

Employer: _____

Referring Physician: _____ Primary Care Physician: _____

How did you hear about us: _____

I hereby authorize Spine & Orthopaedic PT Center through its appropriate personnel to perform appropriate assessment and treatment procedures related to my injury. I further authorize Spine & Orthopaedic PT Center to release any information pertaining to my or my child's healthcare, advice, and treatment to appropriate agencies when requested. I also hereby authorize payment of insurance benefits payable to Spine & Orthopaedic PT Center on my behalf. While the filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of you, the patient or guardian, from the date the services are rendered.

Signature: _____

Date: _____

Spine & Orthopaedic Physical Therapy Center of NJ

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HIPPA: Health, Insurance, Portability and Accountability Act
TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, as well as the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices ad described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Frank Previte, PT
390 Amwell Road Bldg 1 Suite 101 Hillsborough, NJ 08844
Phone #: 908-725-9595 / Fax#: 908-725-9803

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation; and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____ **Date:**_____

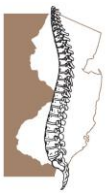
(If this Consent is signed by a personal representative on behalf of the patient, please furnish the name of the personal representative and relationship to the patient. You are entitled to a copy of this intent after you sign it.)

Acknowledgement of Receipt of Notice of Privacy Practices

Optional: Sign again if you'd like a copy of the HIPAA policy.

I, _____have received a copy of this office's Notice of Privacy Practice
Print name

Signature: **Date**:



Spine & Orthopaedic Physical Therapy Center of NJ

OFFICE POLICY

We will gladly discuss your proposed treatment and answer any questions related to your insurance. Please realize, however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Please notify us of any changes in your insurance that occur while you are on program.

In order for us to help you achieve the best rehabilitation results, it is important to keep your scheduled appointments. We require 24 hours' notice when cancelling appointments. ***In the instance of a cancellation without the required 24 hours' notice, or a no-show to a scheduled appointment, you will be charged a $30.00 fee.***

We require that all CO-PAYS and/or DEDUCTIBLES need to be paid at the time of service. Following our receipt of payment from your insurance carrier, all co-insurance is due upon your receipt of our billing statement.

I have read, understand and agree to the terms of the preceding office policy.

Signature of Patient or Guardian_____

Date_____

Spine & Orthopaedic Physical Therapy Center of NJ

Medical History Questionnaire

Height: _____ **Weight:** _____ **Blood Pressure:** _____

Have you or any immediate family member
Been told you/they have the following:

Cancer	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
Angina/Chest Pain	Yes	No
Stroke	Yes	No
Arthritis	Yes	No
Anemia	Yes	No
Ulcers	Yes	No

Do you have any history of:

Shortness of breath	Yes	No
Allergies	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Kidney Disease/Stones	Yes	No
Polio	Yes	No
Emphysema	Yes	No
Rheumatic Fever	Yes	No

Comments/Notes:

Have you had or do you experience:

Nausea/vomiting	Yes	No
Fever/chills/sweaters	Yes	No
Unexpected weight change	Yes	No
Numbness or tingling	Yes	No
Muscular weakness	Yes	No
Fainting spells	Yes	No
Dizziness	Yes	No
Bladder changes	Yes	No
Headaches	Yes	No
Surgery	Yes	No
Urinary Tract Infections (UTI)	Yes	No

Do you smoke? Yes No

If yes, how many packs per day? _____ How long? _____

Do you use alcohol? Yes No

If yes, how many drinks per day? _____ How often? _____

Are you taking medications? Yes No

If yes, what are you taking? _____

How often do you feel stress is a significant factor in your life?

Never _____ Seldom _____ Occasionally _____ Regularly _____ Always _____

Date of last complete physical exam:

Month: _____ Year: _____

Spine & Orthopaedic Physical Therapy Center of NJ

DRY NEEDLING CONSENT TO TREAT FORM

Dry needling (DN) is a skilled technique performed by a physical therapist using a single-use, single-insertion, sterile filiform needle, which is used to penetrate the skin or underlying tissue to effect change in body conditions, pain, movement, impairment and disability. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Receiving dry needling is not to be confused with receiving Traditional Chinese Medicine or acupuncture. They are distinct and different.

Risks of the procedure: The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture, while rare, may require hospitalization.

Other risks may include bruising, infection or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:

- **Are you taking blood thinners? Yes/No**
- **Are you or is there a chance you could be pregnant? Yes/No**
- **Are you aware of any problems or have any concerns with your immune system? Yes/No**
- **Do you have any known disease/infection that can be transmitted through bodily fluids? Yes/No**

Frank Previte, PT has received advanced training and Myopain certification in Dry Needling. Total hours of supervised training are 201.5 hours; 108 academic/theoretical and 93.5 practical application.

Patient's Consent: I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I, (print name) _____authorize the performance of Dry Needling.

_____ _____
Patient or Authorized Representative Date

_____ _____
Relationship to patient (if other than patient) Date

○ I was offered a copy of this consent and refused.