NEOLIFE
PHYSICAL THERAPY & WELLNESS
4016 Cassimer Ave. D'Iberville, MS 39540
P: 228.280.8120 | F: 228.280.8121

Patient Information

Last Name First Name Date of Birth

Street Address City State Zip Code

Home Phone Cell Phone Email Address

Social Security:_____ Marital Status: Married_____ Single_____

Employment Information

Employer Name Work Phone Number

Work Status: Full-Time_____ Part Time:_ Disabled: (_____Total _____Temporary) Student:_____

In Case of Emergency

Emergency Contact Relationship Home Phone Cell Phone

Referral Source

How did you hear about us?

_____Friend or Family_____ _____Other Medical Professional

_____Internet _____Advertisement _____

_____Insurance Directory _____Brochure Referring Physician/Person's Name & Number

Consent for Care & Treatment

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

Responsible Party:_____ Date: _____

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Patient Name:_____

Date of Birth:_____

***Please indicate which payment method(s) you will be using by providing the accompanying information.**

Medical Insurance

Primary Insurance:

Insurance Company:_____Primary Insurance Policy #_____

Insurance Policyholder Name:_____DOB_____Relationship_____

Secondary Insurance:

Insurance Company:_____Primary Insurance Policy #_____

Insurance Policyholder Name:_____DOB_____Relationship_____

Worker's Compensation, Personal Injury, & Auto Accident

Date of Injury/Accident:_____ State:_____

Insurance Adjuster's Name:_____Adjuster's Number:_____

Nurse Case Manager's Name:_____Case Manager's Number:_____

If Applicable: Attorney's Name_____Attorney's Number:_____

Worker's Compensation Acknowledgement

As a Worker's Compensation patient, I am acknowledging that Neolife Physical Therapy & Wellness is mandated to report all patients who do not follow the therapist's prescribed plan of care. If reported for non-compliance I am aware that this may result in a loss of benefits.

Patient Signature:_____ Date: _____

Cash Package

I will be taking advantage of Neolife Physical Therapy & Wellness' cash payment option. Neolife Physical Therapy & Wellness has discussed the packages and payment options available to me.

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Date of Birth:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had the full opportunity to read **Neolife Physical Therapy & Wellness** Notice of Privacy Practices. I understand that by signing this form, I am giving consent to **Neolife Physical Therapy & Wellness** to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I understand the terms of this notice may change with time and **Neolife Physical Therapy & Wellness** will always post the current notice at the clinic, on the website, and have copies available for distribution.

Indicated below are the individuals whom **Neolife Physical Therapy & Wellness** speak with regarding my treatment:

_____

Indicated below are individuals whom I request restriction regarding my protected health information:

_____

We may need to contact you. Do we have permission to leave confidential message at the phone numbers you provide?

_____ Yes _____ No _____Initial & Date

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY - INFORMATION RELEASE

I authorize **Neolife Physical Therapy & Wellness** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to **Neolife Physical Therapy & Wellness** from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and co-insurance and/or deductible as agreed between **Neolife Physical Therapy & Wellness** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner. I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

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

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize **Neolife Physical Therapy & Wellness**, to release all information necessary, including medical records to secure payment.

_____Initial & Date

By my signing below, I authorize that I have read, understand, and agree to the terms and conditions state above.

Patient/Guardian/Responsible Party Signature:_____Date:_____

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Date of Birth:_____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines to ensure the best possible outcome. Please read them carefully, initial each line, and indicate your agreement by signing on the bottom of this form.

_____ **Late Policy:**

If you are more than 10 minutes late, we may require you to reschedule or wait for the next available opening.

_____ **24–Hour Advance Notice for Cancellations & No Shows:**

***Cancellation:** If you wish to change or cancel an appointment, we request a minimum 24-hour advance notice. We understand that life is unpredictable, therefore, we allow a grace period of 2 cancellations without a full 24-hour notice. Beyond that, for additional cancellations, you will incur a $15 fee that will be due at your next appointment.

***No Show:** You are permitted 1 No-Show appointment. Beyond that, you will incur a $15 fee that will be due at your next appointment. If you accrue 3 No-Show appointments, your case with Neolife will be terminated.

_____ **Co-Pays Due at Time of Service:**

Payments for your visit will be collected on the day of treatment upon check-in or check-out.

_____ **Cell Phone Policy:**

Please be courteous and set your phone to silent while you're working with your therapist.

_____**Children Requiring Supervision:**

In order to maintain a productive and therapeutic environment for all of our patients, children who require supervision are not permitted to accompany you to your appointment. If your child is able to wait for you quietly , they are welcome to come. However, if your unsupervised child causes a disturbance with other patients and staff, you may be asked to terminate your session early to tend to your child.

We look forward to working with you and welcoming you to our Neolife Family!

By signing below, I acknowledge that I have read and agree to all of the above listed company policies. I understand that these policies are subject to chance and may require review with additional signature acknowledgement.

Patient/Guardian/Responsible Party:_____Date:_____

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Trigger Point/Dry Needling (TDN) Consent Form

Trigger Point Dry Needling involves placing a small needle into a muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscles and therefore decreasing the symptoms.

TDN is a valuable treatment for musculoskeletal pain. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

- I consent to the performance of Trigger Point Dry Needling on me as part of my treatment plan. I understand the purpose of this procedure is to attempt to alleviate pain and discomfort, and to potentially restore function.
- I understand that this procedure will be performed by a licensed Physical Therapist who has received training and is certified to perform this procedure.
- The nature and purpose of this procedure, the benefits, and risks of the procedure, the possible complication, and the alternatives to this procedure, their benefits and risks have been explained to me.
- I understand that the risks of this procedure are as follows:

  — Though unlikely, there are risks associated with this treatment. The most serious risk 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. The symptoms of shortness of breath may last for several days to a few weeks. A more sever lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and, in skilled hands, should not be a problem.

  — Other risks may include bruising, infection, and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. Because the needles are very small and do not have a cutting edge, significant trauma from TDN is extremely unlikely.
- I consent to the therapist performing different or additional procedures that they deem necessary during the course of this procedure.
- I consent to the use of micro-filament needles for this treatment.
- I acknowledge that no guarantee or assurance has been given by anyone about the results that may be obtained.

- I do not have any allergy or sensitivity to any metals. If I have a metal allergy or sensitivity, I will discuss this with a therapist prior to having this procedure.
- I do not have any known disease or infection that can be transmitted through bodily fluids.

  (If you DO have an infection or disease that can be transmitted through bodily fluids, you MUST disclose this prior to receiving this procedure.) Please discuss this with your practitioner.

By signing below, I am indicating that I have read and acknowledge all of the information above and wish to proceed with TDN.

_____

Patient Printed Name

_____

Patient Signature

_____

Date

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Permission to Use Photograph & Videography

I grant to Neolife Physcial Therapy & Wellness, its representatives and employees the right to take photographs of me and my property in connection with Neolife Physical Therapy & Wellness. I authorize Neolife Physcial Therapy & Wellness, its assigns and transferees to copyright, use, and publish the same in print and/or electronically.

I agree that Neolife Physcial Therapy & Wellness may use such photographs of me with or without my name and for any lawful purpose, including such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above.

_____

Patient Signature

SIGN UP FOR OUR NEWSLETTER!

Fill out this form to receive a monthly newsletter. You may unsubscribe at any time by clicking unsubscribe at the bottom of any email! Thank you!

Name:_____

Email:_____

Patient Name:_____

Date of Birth:_____

Height:_____

Which side is affected? Left Right When did this start? List approximate date_____

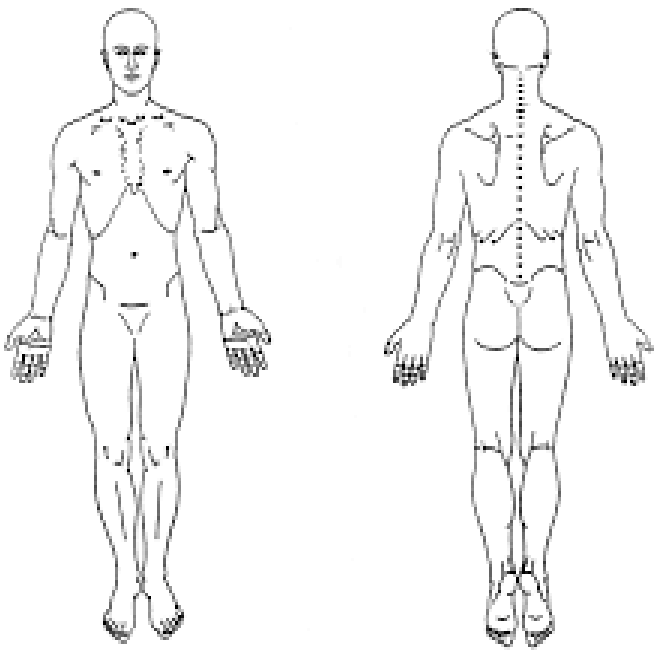
List all past surgeries and/or hospitalizations and their date:

_____

What is your primary concern, complaint, or pain?

_____

Where is your pain/problem? Please indicate your problem area(s) by shading in the affected areas related to your problem



On the following scales, circle your symptom/pain level:

At Worst	0-1-2-3-4-5-6-7-8-9-10
Current	0-1-2-3-4-5-6-7-8-9-10
At Best	0-1-2-3-4-5-6-7-8-9-10

Circle the words that best describe your pain:

Burning	Sharp	Dull/Achy
Throbbing	Shooting	Constant
Intermittent		Worse AM/PM/Night

Please circle anything that makes your issue worse:

Sitting	Standing	Walking
Walking upstairs	Bending	Sit to Stand
Walking downstairs	Lying down	Using the bathroom
Coughing/Sneezing		

Have you ever had this same (or similar) pain/problem before? If yes, when was this and give a description

_____

_____

List any previous treatments you have had for this injury. Include hospitalizations, home health, injection(s), chiropractic or physical therapy.

_____

_____

_____

How would you describe your overall health? Good Fair Poor

Do you have a history of falls? No Yes– How many?_____

Medical History

Please circle all known medical conditions:

Alzheimer's	History of Cancer
Immunosuppression	Lupus
Cardiovascular Disease	Muscular Dystrophy
Obesity	Cerebral Vascular Accident (Stroke)
Current Infection	Osteoarthritis
Diabetes Mellitus Type I	Parkinson's
Diabetes Mellitus Type II	Traumatic Brain Injury
Fibromyalgia	Rheumatoid Arthritis
Fracture or Suspected Fracture	Other:_____

List any diagnostic test or imaging that you have had, such as X-Rays, CT Scans, and MRIs. Include results if known.

_____

_____

Please list your current medications and dosages or provide a list for us to copy.

_____

_____

What are your physical therapy goals?

_____

_____

My follow-up appointment with my medical doctor is scheduled for_____

In your understanding, what do you think will make it better?

_____

What are some potential obstacles to you getting better?

_____

List ONE activity you are unable to do, that you absolutely want to do again. It doesn't matter what it is, we want to know. Sky's the limit!

_____

Over the next 30 days, how many hours per week will you commit to getting better?_____

How optimistic are you that you'll get better?

Not At All Mostly Optimistic Fairly Very Optimistic Extremely