ZOAN
PHYSICAL THERAPY

Legal Name: _____ Date of Birth: _____

Preferred Name: _____

Address: _____ City, State, Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email: _____

Preferred method of communication? (Check)

◯ Text or ◯ Email or ◯ Voice Call

Which number should we text or call?

◯ Home ◯ Mobile ◯ Work

Who may we communicate with about your care? _____

_____

Insurance Company: _____	2nd Insurance Company: _____
ID#: _____	ID#: _____
Sponsor's Name: _____	Sponsor's Name: _____
Sponsor's Date of Birth: _____	Sponsor's Date of Birth: _____
Relationship to patient: _____	Relationship to patient: _____

Physician name: _____ Practice or office name: _____

Current Diagnosis or Problem: _____

_____

Zoan Physical Therapy
Physical Therapy Health Questionnaire

Thank you for choosing Zaon PT for your rehabilitation health care. Please take a few moments to answer the following health related questions to better assist your therapist at meeting your specific needs or concerns.

Name:_____ DOB:_____

Who referred you to us or how did you hear about us?_____

Please list anyone involved in your care or payment for your care with whom we may share your medical information with? _____

Tell us a little bit about what your problem/pain/limitations are: _____

_____

What are your specific goals? _____

_____

MEDICAL HISTORY

Height _____ Weight _____

Please circle any of the following health problems that pertain to you

AIDS/HIV
Allergies
Anemia
Anxiety Disorder
Arthritis
Artificial Joints
Asthma
Bleeding Disorder
COPD
Cancer
Carpel Tunnel
Chronic ear infections
Depression
Diabetes
Difficulty swallowing
Emphysema
Epilepsy/Seizures
Fibromyalgia
Gout
Head Injury/Concussion
Head Trauma/Injury
Headaches/Migraines
Heart Disease
Hernia
High Cholesterol
Hyperlipidemia
Hypertension
Hyperthyroidism
Hypothyroidism
Kidney Disease
Lung Disease
Lyme Disease
Meniere's disease
Multiple Sclerosis
Muscle, Joint, or Bone Problems
Neck Injury
Neurological Disorder
Neuropathy
Organ Transplant
Osteoporosis
Pacemaker
Peripheral Vascular Disease
Polio
Pulmonary Embolism
Reflux/GERD
Rheumatoid Arthritis
Seizures/Epilepsy
Serious Illness or Injuries
Stroke
Thyroid Disease
Thyroid Problems
Heart Arrhythmia
Sports induced asthma

Previous Surgeries? (List Procedures/dates) _____

_____

_____

_____

Prior orthopedic (bones, joints, muscle) injuries or pain?_____

_____

Have you had any eye surgery?_____ If yes, please explain _____
Do you wear glasses or contacts? _____

Have you had braces or jaw surgery? _____ Do you have dental implants? _____
Have you had any teeth pulled? _____ Do you grind your teeth, clench? _____

Do you use a CPAP? _____ Do you snore? _____
Do you wear a dental appliance (mouth guard)? _____ If so, what kind? _____

Any headaches, tinnitus (ringing in the ear), TMJ (jaw pain), anxiety, or depression? (Circle any that apply)

Do you have challenges with sleep? YES NO
Do you have digestive issues? YES NO

Pregnancies? _____ Type of Delivery?_____

List any medications you are allergic to? _____

Please write any medication you are currently taking (including dosage and how often taken): _____

_____

_____

_____

Please list any health problems or conditions that any of your immediate family have or had (Mother, Father, Sister, Brother, and Maternal Grandparents)

_____

_____

SOCIAL HISTORY

Exercise Level? None Occasional Moderate Heavy

Hand Dominance? Right Left Bilateral

Marital Status? Single Married Divorced Separated Widowed Domestic Partner

Occupation? _____

Smoking Status? Never Smoker Former Smoker Current Every Day Smoker Current Some Day Smoker

How much per day? _____ How many years of use? _____

Auto related injury? YES NO Work Related Injury? YES NO
Able to care for self? YES NO

What do you like to do for fun? _____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM!

Zoan Physical Therapy

CONSENT FOR TREATMENT: I, the undersigned, aware that I am suffering from a condition requiring health care, do voluntarily consent to the evaluation and treatment of my condition by the therapists of Zoan PT. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services. I understand that it is the clinics sincere intent to educate me on every process, including billing, treatment and the eventual discharge from their services. Therefore, if instructions or exercise techniques used to retain, recruit, and restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of my therapist's objectives and desired outcomes and how he/she is trying to achieve them. I also hereby consent to have information that may be acquired in the course of my evaluation and treatment studied and reported for research purposes in a manner that will not disclose my identity, as I am aware that this information may be beneficial to others who share my condition.

RELEASE AND ASSIGNMENT OF BENEFITS: I authorize the release of my medical records to process the claim or assist in my medical care. I also authorize Zoan PT to submit insurance carrier claim forms on my behalf without further signature authorization. This also authorizes Zoan PT to receive payment directly from the insurance carrier. All claims forms will be submitted to the carriers with the notation "Signature on File".

DISCLOSURE: We must emphasize that as healthcare providers our relationship is with you, not the insurance company, your employer, or your attorney, and as a courtesy to our patients we will bill your insurance company for you and allow them thirty days to process our claim. We ask that you assist us by working with your insurance company to have our bill processed. In cases of Worker's Compensation or Accidents, should your benefits exhaust or become denied, your private health insurance will be billed. You will be expected to pay all applicable co-pays, co-insurances, deductibles and non-covered or denied services. In the event that your health insurance benefits become exhausted, you (the patient) will then be held responsible for payment towards any subsequent non-covered services.

If your account becomes past due, and is placed with a collection agency, all collection fees will be added to your balance. Fees will, if incurred, include the collection agency's commission, court costs, and interest.

HIPAA: (Health Insurance Portability and Accountability Act) Zoan PT abide by the appropriate policies to keep your health records safe and confidential. You are entitled to a copy of our Privacy Policies.

I HAVE READ THIS FORM AND UNDERSTAND AND ACCEPT THE ABOVE CONSENT FOR TREATMENT, RELEASE, & ASSIGNMENT OF BENEFITS, DISCLOSURE, AND POLICIES AS THEY PERTAIN TO ME. I ALSO ACKNOWLEDGE THE RECEIPT OF PRIVACY POLICIES.

This consent shall be ongoing for a period not to exceed one year. Zoan PT reserves the right to update its policies annually.

_____ _____ _____

Patient's Signature Date Witness (Zoan PT)

(Parent or guardian if patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received the Notice of Privacy Practices from Zoan Physical Therapy.

Signature: _____

Date: _____

Emergency Contact Name and Number: _____

List names of anyone or office that you allow access to your medical records and health information:_____

_____

For Office Use only

In lieu of patient signature, I, _____, a staff member of Zoan Physical Therapy, state that _____ has been given our current Notice of Privacy Practices.

Signature: _____

Date: _____

Payment Policy

Thank you for choosing Zoan Physical Therapy as your physical therapy provider. We are committed to providing you with quality and affordable health care. Please read and sign this payment policy regarding patient and insurance responsibility for services rendered.

1. Insurance. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some of the services you receive may be non-covered or not considered reasonable or medically necessary. You must pay for these services in full at the time of visit.

4. Proof of insurance. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless you contact us regarding a payment plan. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours of your appointment due to the one-one-one care we provide. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Please let us know if you have any questions or concerns regarding this policy.

I have read and understand the payment policy and agree to abide by its guidelines:

_____	_____	_____
Patient's Signature	**Date**	**Witness (ZoPT)**

(Parent or guardian if patient is a minor)

EFFECTIVE IMMEDIATELY

APPOINTMENT CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment cancellation policy. The policy enables us to better utilize available appointments for our patients/clients in need of care.

If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance (24 hour notice). We pride our self on providing one-on-one care and not double booking patients so cancellations without advance notice cause us a loss in revenue and a missed opportunity to get someone else in.

Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

To cancel appointments, please call our office at 864-263-7390. If you do not reach us please leave a detailed message on the voicemail.

Late cancellations will be considered as a "**no show**". A "**no show**" is someone who misses an appointment without cancelling prior to 24 hours.

Personal Training: The charge will be the full amount for the missed appointment.

Physical Therapy

1st Missed Appointment: If rescheduled within the same week there will be no charge. Otherwise, the charge will be $50.00 and is NOT covered by insurance. If you are someone that comes twice weekly and you miss an appointment the $50.00 charge will apply.

2nd Missed Appointment: There will be a $50.00 charge that will NOT be covered by your insurance.

3rd Missed Appointment: You will be charged the $50.00 missed appointment fee and taken off the schedule. You may call in for a same day appointment if there is availability.

Signature: _____ Date: _____

ZOAN Witness Signature: _____

DRY NEEDLING CONSENT &INFORMATION

What is Dry Needling?

Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles): tendons, ligaments or nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental medicine; that is, it does not have the purpose of alternating the ("Q_i_")_ _along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal problems such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, knee pain, shin splints, plantar fasciitis or low-back pain.

Is Dry Needling safe?

Drowsiness, tiredness or dizziness can occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessary a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the neck or head regions. Dry needling is very safe; however, serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is induced pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothrax commonly do not occur until after the treatment session and sometimes it takes several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath (SOB) on exertion, increased breathing rate, chest pain, a dry cough, bluish discolorization of the skin or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician, Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling, however this is very rare event and is usually temporary. Damage to internal organs has been reported in medical literature following needling, however, these are extremely rare events (1 in 200,000).

Is there anything your practitioner needs to know?

Have you ever fainted or experienced a seizure? No/Yes:_____

Do you have a pacemaker or any other electrical implants? No/Yes _____

Are you currently taking anticoagulants (Blood thinners e.g. warfarin, Coumadin) No/Yes_____

Are you currently taking antibiotics for an infection? No/Yes_____

Do you have damaged heart valve, metal prosthesis or other risk for infections? No/Yes_____

Female: Are pregnant or actively trying for a pregnancy? No/Yes_____

Do you suffer from Metal allergies? No/Yes_____

Are you diabetic or do you suffer from impaired wound healing? No/Yes_____

Do you have hepatitis B, C, HIV, or any other infectious disease? No/Yes_____

Have you eaten in the last 2 hours? No/yes _____

Only single- use, disposables needles are used in this clinic.

STATEMENT OF CONSENT

I confirm that I have read and understood the above information, and I consent to having dry needling treatment. I understand that I can refuse treatment and stop it at any time.

Signature: _____

Patient name:_____ **Date:**_____