Elite Physical Therapy & WELLNESS CENTER

Restoring optimal health through specialized care.

2233 Wisconsin Ave. NW, Suite 300
Washington, DC 20007
Phone: (202) 965-8901 Fax: (202) 965-8903

PATIENT INFORMATION

PLEASE PRINT. Fill in forms to the best of your knowledge. Leave blank if not applicable.

Today's Date:_____ / _____ / _____

Name _____ Soc. Sec.#_____-_____-_____
Last Name First Name Initial

Permanent Address _____ City_____ State_____ Zip _____

Temporary Address _____ City_____ State_____ Zip _____

Single Married Widowed Separated Divorced Student / Grade Level:_____ Sex M F (Circle One)

Birth date____ /____ / ____ Age_____ Home Phone Number: ( ) _____- _____ Cell Number: ( ) _____ - _____

Email address_____

Date of Onset of Symptoms: _____ / _____ / _____ Chief Complaint:_____

Patient Employed by _____ Occupation_____

Employers Address _____ Employers Phone Number ( ) _____- _____

Referring Physicians Name_____ Date to return to Physician: _____ /_____ /_____

How did you hear about Elite Physical Therapy & Wellness Center?_____

Have you had any previous physical therapy or chiropractic treatments this year? _____

In case of emergency who should be notified?_____ Phone ( ) _____- _____
Name Relation to Patient

PRIMARY INSURANCE

Name of Insurance Company _____ Insurance I.D.#_____ Group#_____

Policy Effective Date _____/_____/_____ Person Responsible for Acct _____
Last Name First Name Initial

Relation to Patient_____ Birth date_____ /____ / _____

Address (if different from patient's) _____ Phone ( ) _____ - _____

City _____ State _____ Zip _____

SECONDARY / ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No (**Circle One**) Name of Insurance Company**:** _____

Subscriber Name_____ Relation to Patient _____ Birth date _____ / _____ /_____

Address (if different from patient's) _____ Phone ( ) _____ - _____

City_____ State _____ Zip _____

Subscriber Employed by _____ Business Phone ( ) _____ - _____

Name of Insurance Company _____ Soc. Sec.#_____ - _____- _____

Insurance ID # _____ Group #_____ Effective Date of Policy_____/_____/_____

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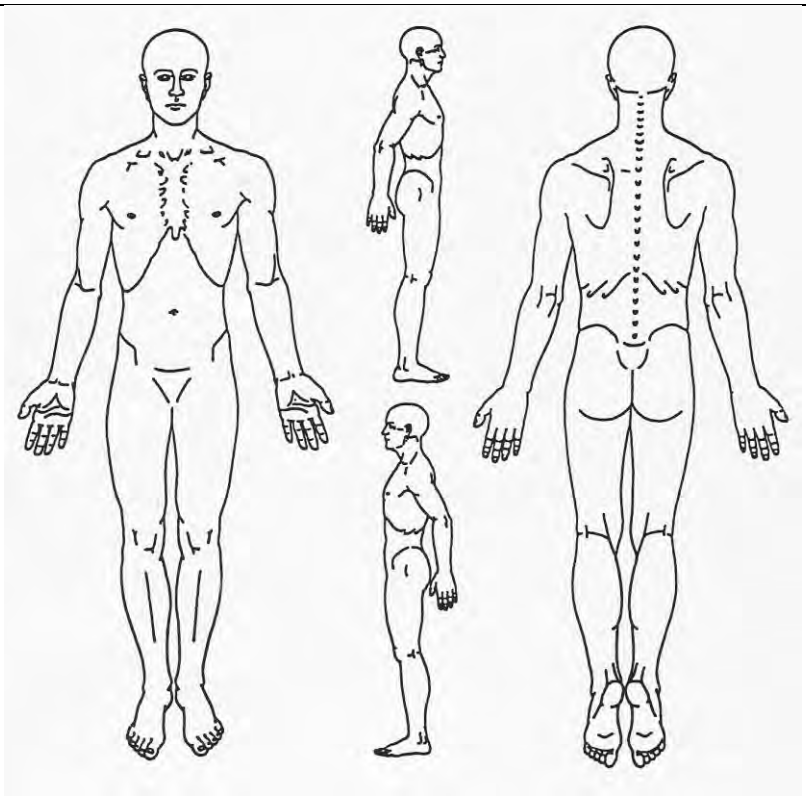
PAIN DRAWING

NAME: (please print)_____DATE:_____

Mark the figures below using the letters that best describe your sensation or pain.

Use ↑, ↓, or ←, → to indicate the direction of radiating or referred pain.

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

If you have multiple areas of pain, write your pain rating next to the body part.

When did the pain begin? _____ Any flare-ups since then? _____ If so, when?_____
What brought the pain on? _____
Is the pain: __ constant __ intermittent
If intermittent, how often does the pain occur? _____
Does it interfere with: __ Work __Sleep __ Daily Routine __Recreation Other_____
Which activities or movements cause pain?
__Sitting __Standing __ Walking __ Bending __ Lying Down __ None __Other_____
When and what makes it feel better? _____
When and what makes it feel worse? _____

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PATIENT MEDICAL HISTORY AND PERSONAL FITNESS QUESTIONNAIRE

The following questionnaire is used to gather information regarding your current and past medical status. Responses to these questions will provide our staff with information required to help determine the safest and most effective treatment for you.

PERSONAL HISTORY

Check each as it applies to you. Have you ever had:

	YES	NO	UNSURE		YES	NO	UNSURE
Allergy				Kidney Problems			
Angina				Leg Cramps			
Arm Pain				Low Blood Pressure			
Asthma				Menstrual Irregularities			
Back pain				Metal Implants			
Blackouts				Motor Vehicle Accident(s)			
Bowel/Bladder Abnormalities				Nervousness			
Cancer				Night Pain			
Chest pain				Osteoarthritis			
Convulsions				Osteoporosis			
Depression				Paralysis			
Diabetes				Poor Tolerance to Heat/Cold			
Dizziness/Fainting				Recent Fractures			
EKG Abnormalities				Rheumatoid Arthritis			
Emphysema				Ringing in your ears			
Gout				Seizures/Neurological Disorders			
Headache				Severe Illness			
Heart attack				Sexual Dysfunction			
Heart Disease				Shortness of Breath			
Hernia				Skin Abnormalities			
High Blood Pressure				Sleep Interference			
Hospitalized				Stroke			
Indigestion/Nausea/Vomiting				T.B.			
Joint Problems				Ulcers			
Joint Sprains							

Have you ever had physical therapy or currently receiving **home health?** yes___ no___
If so, please explain:
_____
_____

Have you ever had any orthopedic injuries, i.e. sprains, strains, fractures, etc.? yes___ no___
If so, please explain: _____
_____

Have you ever had surgery? yes___ no___ If so, what for?
_____
_____

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Any other medical problems? If so, please describe: _____
_____
_____
_____

MEDICAL HISTORY

Name of your family physician_____
Date of last physical (approximately, if unsure) _____
Do you wear a pacemaker? yes___ no___
Do you know your resting blood pressure yes___ no___ _____ mmHg
Do you know your resting heart rate? yes___ no___ _____ BPM
Have you ever had an exercise ECG? yes___ no___
Are you pregnant? yes___ no___

Indicate any medications you are taking:

_____
_____
_____

Please list all drug allergies:

_____
_____
_____

I certify that to the best of my knowledge the above answers are true and accurate.

_____ _____ _____
Signature Printed Name Date

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Please read carefully.

CONSENT FOR TREATMENT

I recognize that I am suffering from a condition requiring physical therapy services and treatment. I hereby consent to the rendering of physical therapy services by Elite Physical Therapy and Wellness Center, as described to me or as my physician or Elite Physical Therapy and Wellness Center determines are necessary. I understand that the practice of physical therapy is not an exact science and that physical therapy treatment involves the risk of injury or even death. I acknowledge that no guarantees have been made to me about the outcome of treatment.

CONSENT OF DISCLOSURE

(For the Usage and/or Disclosure of Protected Health Information)

I hereby give consent to Elite Physical Therapy and Wellness Center and all health care providers furnishing care within Elite Physical Therapy and Wellness Center to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address listed above. This may be delivered in person or by mail, but will only be effective when actually received. Your cancellation will not be effective to the extent that others or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclose of your protected health information for the purposes of treatment, payment, or health care operations. We are not required to grant your request, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by: 1) viewing the copy that is available in our waiting room, or 2) by going to our web site: www.eliteptandwellness.com

(Continued)

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign Elite Physical Therapy and Wellness Center (1) all insurance, Medicare, Medicaid, and other private or governmental benefits payable for my treatments and care; and (2) all rights to payment and all money paid for any claim related to physical therapy service and treatment. Anyone paying or receiving money for my benefits or claims shall pay the money directly to Elite Physical Therapy and Wellness Center for payments of my bills. I understand that I am financially responsible for all charges not covered by my insurance or other third party payers and that any balance after insurance or third party payment has been made is due within thirty (30) days.

I have read and understand this form and the program it describes, and I do voluntarily request the right to participate in Elite Physical Therapy and Wellness Center's rehabilitation program. I do hereby discharge, release, and hold harmless Elite Physical Therapy and Wellness Center and any if it's personnel participating in this rehabilitation program from any and all liability for damage of any kind or character resulting from any injury or condition that I may suffer, or may result from such a rehabilitation program.

THIS FORM HAS BEEN EXPLAINED TO ME AND I SIGN IT VOLUNTARILY.

_____ _____
PARTICIPANT SIGNATURE **DATE**

_____ _____
PARENT OR GUARDIAN SIGNATURE **DATE**

_____ _____
ELITE PT EMPLOYEE SIGNATURE **DATE**

CANCELLATION OF CONSENT
***** Only sign if cancelling consent to disclose information *****

I hereby void the consent given above.
Print Name of Patient:_____

Signature:_____ *Date*:_____

If you are signing as the patient's representative:

Print Your Name:_____

Relationship:_____

Address for cancellation:
Your cancellation will be effective, upon receipt, at the following address:

_____

_____

_____

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KINDLY GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING. FAILURE TO GIVE 24 HOURS NOTICE WILL RESULT IN A $50.00 CHARGE.

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, you may have to reschedule. This is for the benefit of you and other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS ONE WEEK IN ADVANCE TO ENSURE THE TIME THAT YOU NEED. Appointment times given one week do not automatically follow through to the subsequent weeks.

The patient and receptionist have discussed the importance of frequency and duration.

THANK YOU FOR YOUR COOPERATION.

_____ _____
PARTICIPANT SIGNATURE **DATE**

_____ _____
PARENT OR GUARDIAN SIGNATURE **DATE**

_____ _____
ELITE PT EMPLOYEE SIGNATURE **DATE**

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HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

(See provided information notice)

I have been provided with the Notice of Privacy Practices of Elite Physical Therapy & Wellness Center and understand that any questions or concerns regarding this notice may be directed to Elite Physical Therapy & Wellness Center's Staff. If I am unable to sign, a staff member will sign and date this acknowledgement for me. This acknowledgement will be filed in my records.

_____ _____
PARTICIPANT SIGNATURE **DATE**

_____ _____
PARENT OR GUARDIAN SIGNATURE **DATE**

_____ _____
ELITE PT EMPLOYEE SIGNATURE **DATE**

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Patient Information and Consent for Dry Needling as a Procedure
For the Assessment and Treatment of Myofascial Trigger Points and Tender Points

Dry Needling is not acupuncture but uses acupuncture needles to effect a change in myofascial restrictions. Myofascial trigger points and tender points which appear in soft tissue, and are painful sites, reflect abnormal nervous system activity associated with many neuro-musculo-skeletal conditions that are treated in our office. The procedure known as Dry Needling is an important tool for diagnosing, treating, and monitoring changes in myofascial trigger/tender points. During the procedure, a sterile, very thin, solid filament needle is inserted into tissue that may be associated with one or a number of your complaints. One or a number of needles maybe used, and the procedure may be performed during more than one office visit. The number of needles and the frequency of the procedure will depend entirely on your condition at each office visit. There may be some discomfort and little to no bleeding with this procedure. While an infection is an unlikely event with this procedure, whenever there is penetration of the skin, there is risk of infection. Other unlikely but possible events include fainting, soreness, pneumothorax (lung puncture). If you have a fear of needles, a genetic bleeding disorder, a history of a blood disorder that can be transmitted to another person, are regularly taking any blood thinning medication (for example, Coumadin or Warfarin), or are regularly taking any pain relievers containing ibuprofen, NSAIDS, aspirin or acetaminophen (for example, Tylenol, Advil, Aleve, or Bufferin), please inform your physical therapist.

___ I have a fear of needles.

___ I have a genetic bleeding disorder, or history of a blood disorder that can be transmitted to another person.
Please specify:

_____

___ I am regularly taking pain relievers and/or blood thinners.

Please specify:

_____

I have read this Patient Information and Consent carefully. ***I understand this procedure is not acupuncture*** and I have had an opportunity to ask questions and obtain any desired clarification, and I consent to having the procedure of Dry Needling performed on me.

Patient Name (Please print): _____

Patient Signature: _____ Date: _____

If patient is less than 18 years of age, a parent or legal guardian must sign.

Name of Parent/Legal Guardian (Please print): _____

Parent/Guardian Signature: _____ Date: _____