Cascade Sports Injury Prevention & Physical Therapy

Patient Information

Name:_____ Today's Date:_____

Address:_____ Date of Birth: _____

City/St/Zip:_____ Gender: ☐ Male ☐ Female ☐ Non-binary

Home Phone:_____ Email:_____

Cell Phone:_____ Employer:_____

Appt Reminder: ☐ Email* ☐ None **Must provide email above* How did you hear about us?:

☐ Yellow Pages ☐ Yelp ☐ Website ☐ Self Referred ☐ Local Gym_____

☐ Insurance Company ☐ Friend/Family_____ ☐ Doctor_____

Purpose of Visit

Injury:_____ Injury Date:_____

Current pain rating on a scale from 0-10 (0 = no pain, 10 = worst pain) _____

Referring Doctor:_____ Script Date: _____

Have you had surgery for this issue? ☐ Yes ☐ No If yes, Date of Surgery: _____

Type of Surgery: _____

Responsible Party

Person who should receive the bill. Please complete or mark Self.

Name:_____ Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Address:_____ Home Phone: _____

City/St/Zip:_____ Date of Birth:_____

Billing email: _____

Primary Insurance

☐ I have provided a copy of my health insurance card and ID to Cascade Sports.

Primary Policy Holder: _____

Date of Birth: _____

Notify in Emergency

Name:_____ Relationship:_____ Phone:_____

☐ **I certify that the above information provided by me is true and correct to the best of my knowledge.**

Assignment of Benefits: I hereby assign payment directly to **Cascade Sports Injury Prevention & Physical Therapy, LLC**, who represents this clinic to Payer Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any cost incurred regarding collection of payment for services rendered.

_____ _____

Signature **Date**

Cascade Sports Injury Prevention & Physical Therapy

Statement of Financial Policy

Thank you for selecting Cascade **Sports Injury Prevention & Physical Therapy** as your Physical Therapy Provider. We are dedicated to giving each Patient the best care available in a one-on-one setting with the Personal attention you deserve. To help us meet your needs, please familiarize yourself with our financial policy and if you have any questions, please ask for assistance. A copy of this form is available upon request.

Explanation of Insurance Coverage and Insurance Billing: We will be happy to file your insurance claims for you and agree to your insurance company's fee schedule when processing their payment. Regardless of your insurance coverage, your policy is a contract between you and your insurance carrier. You are ultimately responsible for payment which may include a co-pay, coinsurance and/or a deductible. If your claim is denied due to lack of coverage or your insurance company does not pay for the services rendered, you will be responsible for the entire balance on your account.

Please be advised that all Co-Pays, Payments towards deductible, and Cash Pay services are due at time of service. We accept Visa/Mastercard/Discover, Apple Pay/Google Pay, checks, and cash. A fee of $25 will be charged on all returned checks.

No-show/cancellation policy: We realize that, on rare occasions, you may need to reschedule or cancel an appointment. Please contact our office at (303) 484-1232 *at least 24 business hours before your scheduled appointment* to cancel and reschedule your appointment. A fee of $45 may be charged if you fail to do so.

Financial Responsibility: I agree to be personally and fully responsible for payment of services rendered in accordance with my insurance benefits (as outlined above) and for non-covered services. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney fees and collection expenses.

*To opt out of paperless invoicing, please inform the front desk.

_____ _____

Signature Date

Consent to Treat

I authorize the provider in charge of the care of the patient listed below to provide diagnosis and treatment of services while a patient at Cascade Sports Injury Prevention & Physical Therapy.

I authorize the release of any medical information necessary to process payment for services rendered.

_____ _____

Signature Date

Print patient name: _____

Cascade Sports Injury Prevention & Physical Therapy

Patient Medical History

Do you have, or have you had, any of the following? Please check **ALL** that apply.

___ High blood pressure
___ Change in ability to taste food
___ Heart problems
___ Vocal changes
___ Shortness of breath
___ Ear pain
___ Changes in hair or nails
___ Headaches
___ Diabetes
___ Mental illness
___ Low blood sugar
___ Numbness / tingling
___ Thyroid problems
___ Arthritis
___ Difficulty sleeping while lying flat
___ Muscle cramps
___ Lung problems
___ Broken bones in last year
___ Asthma
___ Surgery related to the problem
___ Ulcers we are seeing you for
___ Cancer
___ Varicose veins
___ Night sweats
___ Hot or cold intolerance
___ Nausea, vomiting
___ Productive coughing

___ Bleeding or bruising
___ Any contagious diseases
___ Tumors
___ Rashes
___ Lumps, bumps
___ Fever
___ Unexpected weight gain/loss in last 6 months
___ Bowel or bladder changes
___ Pelvic inflammatory disease
___ Long-term steroid use
___ Bladder or kidney infection
___ Osteoporosis
___ Abnormal /painful menstruation
___ Head Trauma/Stroke/TIA
___ Incontinence
___ Loss of consciousness/fainting/blackouts
___ Currently pregnant
___ Change in vision
___ Difficulty eating / swallowing
___ Dizziness
___ Balance problems
___ Ringing in ears
___ Major dental work
___ Do you smoke? (Y/N)
___ Do you drink alcohol? (How often?___/week)
___ Do you exercise? (How often? ___/week)

Comments or things we should know about you: _____

_____

Have you had physical therapy for this condition? Yes / No

Please take a moment to carefully read the information and sign where indicated. If you have a specific medical condition or specific symptoms,physical therapy may be contraindicated. A referral from your primary care provider may be required prior to service being rendered. I understand that physical therapy should not be construed as a substitute for medical examination or diagnosis and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. Because physical therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Patient Name: _____ Date of Birth: _____

Cascade Sports Injury Prevention & Physical Therapy

Release of Information and HIPAA

Release of information:

I authorize any physician, hospital, school, referring agency or other person who has records pertaining to treatment at **Cascade Sports Injury Prevention & Physical Therapy** to release such records, upon request, to our facility. Furthermore, I authorize **Cascade Sports Injury Prevention & Physical Therapy** use or release of any of my records it may have to third party payors, government agencies, healthcare providers or other organizations that may assist them in meeting my healthcare needs. I may revoke this authorization in writing at any time and that such revocation will be effective as of the date the written revocation is received by **Cascade Sports Injury Prevention & Physical Therapy.**

Privacy Notices:

You, the below named patient, are entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). During the course of treatment, we collect paper and/or electronic records describing your health history, symptoms upon examinations and test results, diagnoses, treatment and any plans for future care or treatment. You understand that this information serves as:

- A basis for planning my care and treatment
- A means by which third party payers can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

You have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of your health information for directory purposes
- The right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment or health care operations.

We treat this information as confidential and realize the importance of protecting that information. A complete copy of our HIPAA Privacy Practices is available upon request.

I have read the above information and fully understand and accept the terms of this consent.

_____ _____

Signature Date

Cascade Sports Injury Prevention & Physical Therapy

Trigger Point Dry Needling Consent Form

Trigger point dry needling (TDN) involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release. This response improves the flexibility of the muscle and therefore decreases muscular-based symptoms. TDN is not intended to stimulate any distal or auricular acupuncture points. 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 to treatment.

Risks of TDN

The most serious risk associated with TDN 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 several weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include excessive bleeding (causing a bruise), infection and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely. The needles are sterile and our therapists utilize clean blood borne pathogen precautions in order to minimize the chance of infection.

Please consult with your practitioner if you have questions regarding the treatment above.

I have read, or been read, and understand the above information, and hereby give consent for Trigger Point Dry Needling procedures to be performed on me by a TDN trained Cascade Sports physical therapist. All TDN trained physical therapists have met the requirements set by the Colorado Department of Regulatory Agencies for the safe use of this intervention technique. This consent may be revoked at any time verbally or in writing.

_____	_____	_____
Please Print Name	Please Sign Name	Date

Cascade Sports Injury Prevention & Physical Therapy

Blood Flow Restriction (BFR) Payment Consent Form

What is BFR?

Blood flow restriction is an arterial occlusion cuff intended to be used by certified health care professionals to increase muscular strength and endurance.

Blood flow restriction occludes the artery with a pressure cuff at 60-80% of total pressure of the artery. This can be performed on upper extremities or lower extremities.

How does it work?

The lack of blood flow created by the cuff creates an increase in oxygen demand for the muscle. This gives the feeling of "burn" within 30 repetitions of an exercise that would typically be very easy. The lack of oxygen coupled with exercise causes a release of hormones that are vital for muscle, cell, and tendon growth. This results in cell swelling and strength gains to the area targeted.

Who can benefit from BFR?

Many people can benefit from BFR because it allows for high level strength training without putting the joints, tendons, and ligaments of our bodies under high tension.

Some common diagnoses that often benefit from BFR:

- Post-op knee surgery
- Post-op rotator cuff surgery
- Post-op ankle surgery
- Patellar/ Achilles tendinosis
- "Golfers" or "tennis" elbow
- Chronic weakness of single extremity (typically from unresolved injury)
- Runners and cyclists to increase VO2 max with less time under tension

Additional Fee for BFR

BFR is currently not covered by insurance companies. Cascade charges an annual service fee of $99.00 for use of BFR. This fee allows us to stay up to date with training and maintenance, and will only be assessed if BFR is used. If you would like further information, please discuss with your treating physical therapist.

☐ **I have read and understand the above information, and I consent to pay $99.00 annually if BFR is used.**

_____ _____

Signature Date

_____ _____

Printed name Date of birth