TOPS PHYSICAL THERAPY, LLC
REGISTRATION FORM

(Please Print)

Today's date:	Diagnosis:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (check one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( ) -

	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( ) -

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Have you received previous physical therapy this year? ☐ YES ☐ NO If yes, how many _____

INSURANCE INFORMATION

(Please give your insurance card to the front office)

Responsible Party:	Birth date: / /	Address (if different):	Home phone no.: ( ) -

	Employer:	Employer address:	Employer phone no.: ( ) -

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Insurance:	Address:	Phone no.: ( ) -

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Member ID #:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TOPS PHYSICAL THERAPY,LLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

TOPS PHYSICAL THERAPY, LLC

THE ORTHOPEDIC & PERFORMANCE SPECIALISTS

The Madison
5353 North 16th Street Suite 120
Phoenix, AZ 85016

Phone: 602-826-0037
Fax: 480-275-6310

Patient Consent for Assessment and Treatment

Physical Therapy treatment techniques may include, but are not limited to: manual techniques, spinal manipulation, electrotherapeutic modalities, and therapeutic exercises. These may be recommended during your program. It is the policy of ***TOPS Physical Therapy*** to ensure that the benefits, side effects, and potential complications of each chosen modality above are explained to you by your therapist. Throughout the program, should you have concerns, or questions about any recommended treatment, you must inform the therapist immediately so rationale for treatment and/or adjustments can be made. It is your responsibility to participate in all aspects of the program as it is imperative to its success.

I understand and agree with the above policy. I give consent for TOPS Physical Therapy to provide me with an assessment and also treatment for services. I understand that I can withdraw my consent at any time.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian (If patient is minor) Date

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
SUMMARY OF NOTICE TO PRIVATE PRACTICES

The Notice of Privacy practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health information. We will use and disclose your health information in order to treat you or to assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limit operational activities such as quality assessment, licensing, accreditation, and training of students or staff.

Uses and Disclosures Based on your authorization. Expect as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written consent.

Uses and Disclosures not requiring your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members to close friends who are involved in your healthcare
- For purposes of public health and safety
- To Government agencies for purposes of their audits, investigations, and other oversight activities:
- To Government authorities to prevent child abuse or domestic violence
- To the FDA to report product deficits or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, subpoenas, and as otherwise required by law

Patient rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate to you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you have a question, concern, or complaint regarding our privacy practice, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

HIPAA Contact: Teri Brannon

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Phoenix, AZ 85016

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Patient Consent for Use and Disclosure of Protect Health Information

I hereby give my consent to TOPS Physical Therapy to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent, TOPS PHYSICAL THERAPY reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: TOPS PHYSICAL THERAPY, 1928 E Highland Ave F104 Suite 460, Phoenix, AZ 85016.

With this consent, TOPS Physical Therapy may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

By signing this form, I am consenting to allow TOPS PHYSICAL THERAPY to use and disclose my PHI to carry out TPO.

_____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Print Patient's Name | Date

_____

Print Name of Legal Guardian, if applicable

TOPS PHYSICAL THERAPY

THE ORTHOPEDIC & PERFORMANCE SPECIALISTS

Madison Square
5353 North 16th Street Suite 120
Phoenix, AZ 85016

Phone: 602-826-0037
Fax: 480-275-6310

2017 Insurance Disclaimer

Insurance Disclaimer:

As a service to our patients, TOPS Physical Therapy will verify benefits with your insurance company and submit charges for medical services. A quote of benefits and/or authorizations does not guarantee payment or eligibility. Payment of coverage from your insurance are subject to all terms, conditions, limitations, and exclusions of your contract at time of service. However, the patient is primarily responsible for paying any and all deductible, coinsurance, and copay amounts.

Copays will be due at the time of service whereas deductible/coinsurance will be due on/around the 15th and 30th of each month during the duration of your treatment with TOPS.

Insurance Liability for Payment:

Your health insurance company will only pay for services that is determines to be "reasonable and necessary" Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not "reasonable and necessary", or that a particular service is not covered under the plan, your insurer will deny payment for that service. Our office will make every effort to work with your insurance company to justify our services as medically necessary.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Patient Name/Date_____

T.O.P.S. Physical Therapy now offers our patients the opportunity to have appointment reminders via email.

Patient Name: _____ E-mail Address: _____

HOW WE WILL USE E-MAIL

1) We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.

2) We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:

o Appointment scheduling, billing or payment questions or correspondence.

3) We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

Please be advised that the Stools have a potential risk when sitting on them. Please be cautious when sitting, and use two hands to secure stool beneath you.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from TOPS Physical Therapy.

I have also been informed of the potential risk of using the STOOLS in the facility.

Signature _____ *Date*_____

T.O.P.S.
PHYSICAL THERAPY
"THE ORTHOPEDIC & PERFORMANCE SPECIALISTS"

CANCELLATION POLICY

Thank you for choosing T.O.P.S Physical Therapy!
We are committed to the success of your treatment and care.

We understand that on rare occasions, issues may arise causing you to miss your appointment without the ability to notify our office. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office to have it rescheduled.

Our highly skilled Therapists are committed to your wellbeing, and have reserved time just for you.

If you miss more than three appointments without notifying our office prior, you will be subject to a **$35 missed appointment fee.**

I have read, understand, and agree to the above Cancellation Policy.

_____	_____	_____
Date	**Signature**	**Printed Name**

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Dry Needling Consent & Information Form

What is Dry Needling?

Dry needling is a form of therapy in which fine needle are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments or near 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 altering the flow of energy ("Qi") along traditional Chinese meridians for the treatment of disease. In fact, dry needling is a modern, science- based intervention for the treatment of pain in dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis or low back pain.

Is Dry Needling safe?

Drowsiness, tiredness or dizziness 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 or 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 necessarily a "bad "sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck 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 pneumothorax (lung collapse due to air inside the chest wall).The symptoms of dry needling- induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration 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 a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000).

Is there anything your practitioner needs to know?

1. Have you ever fainted or experience a seizure? Yes / No
2. Do you have a pacemaker or any other electrical implant? Yes/ No
3. Are you currently taking anticoagulants (blood – thinners e.g warfarin, Coumadin)? Yes/ No
4. Are you currently taking antibiotics for an infection? Yes/ No
5. Do you have a damaged heart valve, metal prosthesis or other risk of infection? Yes/ No
6. Are you pregnant or are actively trying for a pregnancy? Yes/ No
7. Do you suffer from metal allergies? Yes/ No
8. Are you a diabetic or do you suffer from impaired wound healing? Yes/ No
9. Do you have hepatitis B, hepatitis C, HIV or any other infectious disease? Yes/ No
10. Have you eaten in the last two hours? Yes/ No

Only single- use disposable needles are used in the clinic.

Statement of consent

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

Signature _____

Printed Name_____ Date_____

This document contains an unofficial version of the new rules in 9 A.A.C. 10, Article 10, Effective July 1, 2014.

ARTICLE 10. OUTPATIENT TREATMENT CENTERS

R9-10-1008. PATIENT RIGHTS

An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Except as allowed in R9-10-1012(B), restraint or seclusion;
   i. Retaliation for submitting a complaint to the Department or another entity; or
   j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
   d. Is informed of the following:
      i. The outpatient treatment center's policy on health care directives, and
      ii. The patient complaint process;
   e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
   f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record, or
      ii. Financial records.

A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Signature: _____ Date: _____