NEW PATIENT FORM

LARRY HESS
PREFERRED CHOICEPT
P: 571.293.1511 **E:** Larry@PreferredChoicePT.com
44933 GEORGE WASHINGTON BLVD #165, ASHBURN, VA 20147

Name (First/Middle/Last): _____

Primary Phone: _____ Date of Birth: _____

Emergency Contact: _____ Phone Number: _____

Email: _____

Address: _____

City State Zip

Sex: ☐Male ☐Female Marital Status: ☐S ☐M ☐D ☐W

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Student

Occupation: _____ Employer: _____

Responsible Party Name (For Minors): _____

Relationship to Minor_____

Address (if different from above): _____

City State Zip

Phone Number: _____

Physician Referred By: _____

Physician Phone Number: _____

How did you hear about Preferred ChoicePT? _____

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MEDICAL HISTORY

Chief Complaint: _____

Date of Injury: _____ Type / Date of Surgery: _____

How Injury Occurred: _____

Treatment for Injury: ☐Doctor ☐Physical Therapist ☐Chiropractor ☐Massage Therapist ☐Other

Diagnostic Testing or Procedures: ☐X-ray ☐MRI ☐CT Scan ☐Injections ☐Diagnostic Ultrasound ☐Other

Past Injury History: _____

Previous Surgery / Dates: _____

PLEASE CHECK IF YOU HAVE, OR HAD ANY OF THE FOLLOWING BELOW

☐Arthritis	☐Heart Disease	☐High Blood Pressure	☐Chest Pain/ Angina	☐Pacemaker/ Defibrillator
☐Blood Disorder	☐Diabetes	☐Asthma	☐Allergies (list below)	☐Cancer (type)
☐Seizures	☐Thyroid Issues	☐Gout	☐Multiple Sclerosis	☐Bone Fractures
☐Osteoporosis /Osteopenia	☐Head Injury / Concussions	☐Stroke	☐Parkinson's Disease	☐Kidney Disease
☐Bowel / Bladder Disease	☐Skin Diseases	☐Ulcers	☐Tuberculosis	☐HIV / AIDS
☐Hepatitis	☐Development or Growth Problem	☐COVID 19	☐Tobacco Use	☐Alcohol Use
☐Pregnant	☐Anxiety	☐Depression	☐Metal Implants	☐Dizziness or Fainting
☐Other (List)				
☐NONE				

What is your goal with Physical Therapy? _____

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PAIN HISTORY

(Circle the number that best corresponds to your pain)

	none										excruciating
Current Pain Level:	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10
Level: Best	0	1	2	3	4	5	6	7	8	9	10
Level:											

Pain Increases with (check all that apply)

☐Sitting ☐Standing ☐Lying down ☐Stairs up ☐Stairs down ☐Walking ☐Running

☐Change of Direction ☐Jumping ☐Lifting ☐Reaching ☐Squatting ☐Bending

☐Worse in AM ☐Worse in PM ☐Worse as day progresses ☐Heat ☐Ice

☐Other: _____

Pain Decreases with (check all that apply)

☐Sitting ☐Standing ☐Lying down ☐Walking ☐Bending ☐Movement ☐Rest

☐Better in AM ☐Better in PM ☐Better as day progresses ☐Medication ☐Ice ☐Heat

☐Other: _____

Please list all medications you are currently taking and dosages:

_____

_____

_____

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ACKNOWLEDGEMENTS & CONSENT - RELEASE OF HEALTH INFORMATION

I give permission to Preferred ChoicePT to release information, verbal and written, from my medical records to my physician, insurance company, case manager, attorney, school, related healthcare provider, or other agencies as it relates to my treatment. I further authorize Preferred ChoicePT to obtain medical records from my physician or other medical professionals as related to my treatment.

I give consent for Preferred ChoicePT to call, email, or mail my home or other designated locations. Preferred ChoicePT may also leave a message on voicemail or in person in reference to appointments and any issues pertaining to my clinical care.

Sign Here: _____ Date: _____

DISCLOSURE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I have read and fully understand Preferred ChoicePT's Privacy Practices. A copy of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that Preferred ChoicePT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Preferred ChoicePT will consider requests for restriction on a case-by-case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Preferred ChoicePT's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Sign Here:_____ Date:_____

COMMUNICATION OF HEALTH INFORMATION

I give permission to Preferred ChoicePT to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name: _____ Relationship: _____ Contact Info: _____
Name:_____ Relationship:_____ Contact Info:_____
Name: _____ Relationship: _____ Contact Info: _____

I do not wish to disclose any information related to my medical condition(s)

Sign Here:_____ Date:_____

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FINANCIAL / SCHEDULING POLICY

Preferred ChoicePT is committed to providing you with the best possible care. This information is designed to guide you through the rapidly changing world of physical therapy and insurance plans. Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures.

Here at Preferred ChoicePT, we feel that we can best care for our patients if we are able to spend up to a full hour with them on their first appointment. Because of the high demand for these appointments, it is critical that you arrive in the office 10 minutes prior to your appointment with your completed forms. We understand that delays can happen, however, we must try to keep the other patients and therapists on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

We understand situations arise in which you must cancel your appointment. It is therefore requested if you must cancel or reschedule your appointment, you provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations / reschedules made less than 24 hours notice, we are unable to offer that appointment to other patients.

There will be a $150.00 fee charged to all patients / clients who miss scheduled appointments and fail to cancel their scheduled appointment without 24 hours notice. We understand that illness and emergencies happen and we will take that into full consideration if the situation arises and will waive the fee as necessary. Patients who No Show two (2) or more times in a three (3) month period, may be dismissed from the practice thus being denied any future appointments.

Preferred ChoicePT is an out of network Physical Therapy practice. Payment is to be provided on the date of services unless payment arrangements have been made and approved in advance. We will provide the appropriate invoice so that you may submit the service provided to your insurance company for possible reimbursement. For your convenience, we accept all major credit cards and payments can be made over the phone.

PLEASE NOTE THAT YOU WILL BE CHARGED $35.00 FOR ANY CHECKS WITH INSUFFICIENT FUNDS.

Sign Here: _____ Date: _____

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DRY NEEDLING CONSENT

Dry needling involves inserting a tiny monofilament needle in a muscle(s) in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese acupuncture, but instead is a medical treatment that relies on a medical diagnosis to be effective. Dry needling is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with dry needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms are shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, this consent will cover this treatment as well as consecutive treatments by Preferred ChoicePT. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Please answer the following questions:

1. Have you ever fainted or experienced a seizure? ☐ Yes ☐ No
2. Do you have a pacemaker or any other electrical implants? ☐ Yes ☐ No
3. Are you currently taking anticoagulants (ex: Aspirin, blood thinners)? ☐ Yes ☐ No
4. Are you currently taking antibiotics for an infection? ☐ Yes ☐ No
5. Do you have a damaged heart valve, metal, or other risk of infection? ☐ Yes ☐ No
6. Are you pregnant? ☐ 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, C, HIV, or any other infectious disease? ☐ Yes ☐ No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM. You have the right to withdraw consent for this procedure at any time before it is performed.

_____ _____

Patient or Authorized Representative Date

Relationship to Patient (if other than patient)

_____

Patient Name Printed

_____

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

_____ _____