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

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?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

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

E-mail:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Google, Yelp, Facebook, Social Media
☐ Family ☐ Friend ☐ Close to home/work ☐ Hospital ☐ 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 T.O.P.S. PHYSICAL THERAPY,LLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

5353 N. 16th St Suite 120 · Phoenix, AZ 85016
Tel: 602.826.0037 · Fax: 480.275.6310
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T.O.P.S.
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Consent:

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.

_____
Initial

Privacy Notice

Please review our Privacy Policy before continuing (see next page HIPAA-A Guide To Your Medical Information)

A copy of our privacy notice has been offered to you. This describes how your personal medical information may be used, disclosed, and communicated which may include email or text. PLEASE REVIEW IT CAREFULLY and let us know if you require any exceptions.

*Privacy Policy Exclusion: I request the following restrictions:_____

_____
Initial

Financial Policy

Thank you for choosing us as your health care provider. The following is an explanation <of our financial policy, which we require you to read and sign prior to any treatment. If you need additional information or clarification, our front office staff will be glad to address any questions that you may have.

FULL PAYMENT OF ANY COPAYS OR DEDUCTIBLES IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, checks, debit cards, VISA, and MASTERCARD. A $35 service fee will be charged on all returned checks. If a check is returned, all subsequent payments must be made by cash, cashier's check, money order or by debit card, VISA, or MASTERCARD.

Under no circumstances will the Practice waive coinsurance, deductible or any other similar expense and then bill the insurance carrier for these fees.

We charge fees, which are reasonable and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Health Insurance: Every attempt will be made by our office to help you so that your insurance carrier will make proper reimbursement for services performed at this office. However, please remember that your insurance contract is made between you and your insurance carrier and not with our office. Your insurance rules and benefits are specified in your contract.

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Consent:

You are responsible for knowing your benefits and following the rules of your plan. Verification of your insurance or the receipt of a prior authorization does not guarantee payment by your plan. The ultimate obligation for payment of services rests with you. Please contact your insurance company regarding co-pays or deductible requirements.

I, (the patient) also understand and acknowledge that I am personally responsible to pay TOPS Physical Therapy, LLC., in full for services that my health insurer will not cover due to nonpayment of my health insurance premiums.

Participating Provider Plans: If we are contracted with or are participating providers with your insurance plan, we will submit your claim to your insurance company. If your insurance company has not paid your account in full within 45 days, we may request your assistance in collecting from your carrier.

If you insurance company requires a referral, you are responsible for obtaining that referral prior to the services being rendered. This needs to be done for each visit to our office, if necessary.

Private insurance: As a courtesy, we will submit a claim to your private insurance. If your insurance does not respond to our claim within 30 days, you will be responsible for the entire balance of your account. Additionally, once your insurance sends us payment for your services, any balance not paid in full by them will be your responsibility.

Medical Records Fees: There will be a fee of $20.00 for up to 50 pages, and anything over 50 pages is $40.00 to copy records. We will provide records to your physician, with a signed consent, at no charge.

Missed Appointments: If you need to cancel an appointment, kindly provide at least 24 hours notice so that we may offer that appointment time to another patient. Failure to provide TOPS Physical Therapy 24 hours notice of need to cancel an appointment, or failing to appear for a scheduled appointment (No Show) will result in a $35.00 charge.

Interest: We reserve the right to charge interest in the amount of 10% as provided by state law. If a payment is not kept current and we are forced to send your account to collections, we will add the 33 1/3% collection fee to your total balance.

Financial Policy Acceptance:

I certify that I have read and fully understand the financial policies of TOPS Physical Therapy, LLC.

_____
Initial

Stool Policy

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.

_____
Initial

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Consent:

Patient Rights

This document contains an unofficial version of the new rules in 9 A.A.C. 10, Article 10, Effective May 1, 2016.
ARTICLE 10. OUTPATIENT TREATMENT CENTERS- R9-10-1008. PATIENT RIGHTS

A. An administrator shall ensure that:
1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
    a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
    b. Where patient rights are posted as required in subsection (A)(1).

B. 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. 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.

_____
Initial

Signature: _____ Initial: _____

Printed Name:_____ Date:_____

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T.O.P.S. PHYSICAL THERAPY & OSTEOPRACTICS
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HIPAA
A GUIDE TO YOUR MEDICAL INFORMATION

TOPS Physical Therapy
TOPS Physical Therapy LLC

Amy Brannon, Practice Manager-Owner
Teri Brannon, Operations Manager

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

REQUIRED USES OF YOUR MEDICAL INFORMATION

- As required by law, lawsuits, legal actions or law enforcement.
- To protect victims of abuse or neglect.
- For federal and state health oversight, such as fraud investigations.
- To avert serious threat to public health or safety or National Security.
- To the extent necessary to comply with laws relating to workers compensation if you are injured at work.
- To a correctional institution if you are an inmate.
- To provide information as part of health oversight activities as authorized by law.

DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

Disclosure of Psychotherapy Notes: We may not disclose psychotherapy notes that may be contained in our record without a written authorization from you unless required by law.

Marketing: Your written authorization is required for us to use or disclose your information for marketing purposes to a third party.

Requests by you: You may request copies of your medical records to be sent to a third party, Ex: Attorney or Employer. This request must be provided in writing. Request the authorization form from the Operations Manager.

HOW WE ROUTINELY USE MEDICAL INFORMATION

Treatment: We will share your medical information to provide or coordinate your health care. This includes the coordination of your health care with a third party, such as your physician, nurse practitioner, worker's compensation case manager or anyone else who provides you care.

Payment: We may use your information in order to obtain authorizations and for payment for the services and items that you may receive from us.

Health Care Operations: We may use your medical information to evaluate the quality of care you receive from us.

Appointment Reminders: We may contact you for appointment reminders or rescheduled appointments.

Patient Sign-in Sheets: We will use your name on our daily patient sign-in sheet.

Email / Text: We may email / text to communicate information such as clinic updates, need to cancel or reschedule an appointment, to answer a question or provide an update about your treatment or home program. Email / texting has inherent risks but can be a beneficial form of communication. For more complex issues regarding your injury and treatment, we recommend discussing it either in the clinic or via telephone.

Release of Information to Family/Friends: We may disclose to a family member or friend medical information that is necessary for their involvement in your treatment and care.

Newsletters and Other Communications: We may use your personal information in order to communicate to you via newsletters (including electronic newsletters), mailings, or other means regarding treatment options, health related information, or other community based initiatives or activities in which our practice is participating.

Sale of PHI: We will never sell your PHI.

YOUR RIGHTS

Confidential Communications: You have the right to request that we communicate with you in a particular manner such as a specific address or telephone number. This should be given to the operations manager in writing.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your medical information. The request must be in writing. We are not required to agree to these restrictions. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Self Pay: If your request is to restrict a disclosure of medical information for a healthcare item or service for which you or someone else has paid in full (other than your health plan), we are required to agree to this request and will restrict the disclosure unless otherwise required by law.
In order to request a restriction in our disclosure of your PHI, you must make your request in writing to the Operations Manager.

Inspection and Copies: You have the right to inspect and obtain a copy of your medical record (not including psychotherapy notes). You must make the request in person or in writing to the Operations Manager in order to inspect and/or obtain a copy of your medical record (fees may apply).

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete as long as the information is kept by TOPS Physical Therapy. To request an amendment, your request must be made in writing and submitted to the Operations Manager. You must provide us with a reason that supports your request for amendment.

Right to Receive Notice of a Breach: We are required to notify you of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.

Accounting of Disclosures: All of our patients have the right to request an "accounting of disclosures." An accounting of disclosures is a list of disclosures or your authorizations that the Practice has made of your medical information. In order to obtain an accounting of disclosures, you must submit your request in writing to the Operations Manager.

Right to File a Complaint: If you have a question, concern, or complaint regarding our privacy practice, please contact Teri Brannon (HIPPA Contact) at 602-826-0037.

OUR COMMITMENT TO YOUR PRIVACY

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your name, address and insurance information, referral/records from other providers, your symptoms, examinations, treatment, and a plan for future care. This information is referred to as your medical information, medical record, or protected health information (PHI).

As our patient your privacy is a priority. We are committed to following federal and state guidelines to maintain the confidentiality of your medical information.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all of your records with TOPS Physical Therapy.

Your privacy rights are important to us. If you have any questions regarding this notice or our privacy policies, please ask the Operations Manager or Practice Manager.

Effective – April 16, 2018

I certify that I have read and fully understand the HIPAA-A GUIDE TO YOUR MEDICAL INFORMATION of T.O.P.S. PHYSICAL THERAPY,LLC.

Signature: _____

Printed Name:_____ Date:_____

T.O.P.S.
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Dry Needling Consent 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:_____

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