PERSONAL INFORMATION

PLEASE COMPLETE ALL SECTIONS		
NAME	HOME PHONE	CELL PHONE
ADDRESS	CITY	ZIP CODE
EMPLOYER	MARITAL STATUS	
BIRTHDATE	EMAIL ADDRESS	SEX
DO YOU HAVE A REFERRAL?	REFERRING PHYSICIAN:	
SOCIAL SECURITY NUMBER	PREFERRED METHOD FOR NOTIFICATION OF APPOINTMENTS: ____EMAIL ____TEXT MESSAGE	
EMERGENCY CONTACT NAME	PHONE	RELATIONSHIP

DATE OF RECENT INJURY OR WORSENING OF SYMPTOMS:	BODY AREA BEING TREATED/DIAGNOSIS:
ARE YOU CURRENLTY RECEIVEING HOME HEALTH SERVICES?	AVERAGE PAIN LEVEL (0-10)
ANY UPCOMING PROCEDURES OR PHYSICIAN VISITS?	WHAT IS YOUR GOAL FOR THERAPY?

Are your symptoms? ☐ improving, ☐ becoming worse, or ☐ staying the same?

ClearCut® ORTHO

MEDICAL HISTORY

What are you being seen for today? _____

Do you feel you understand your diagnosis? _____

Has a medical provider given you any exercise restrictions: ☐ yes ☐ no
If yes, please explain: _____

Are you currently engaged in any form of exercise: ☐ yes ☐ no
If yes, please explain: _____

Are you currently working full duty: ☐ yes ☐ no
If no, please list any limitations: _____

If you are not working due to your injury, when do you anticipate returning to work: _____/_____/_____

Do you now have or have you ever had any of the following?

- ☐ Allergies
- ☐ Asthma/Bronchitis/Breathing Restriction
- ☐ Emphysema/Shortness of Breath Chest Pain
- ☐ Coronary Heart Disease or Angina High
- ☐ Blood Pressure
- ☐ Heart Attack or Heart Surgery Stroke
- ☐ Congestive Heart Failure
- ☐ Blood Clot/Emboli
- ☐ Varicose Veins

- ☐ Thyroid Disease or Goiter
- ☐ Anemia
- ☐ Infectious Disease (HIV, Hepatitis, etc)
- ☐ Diabetes Type 1 or 2
- ☐ Low or High Blood Sugar
- ☐ Kidney or Liver Problems
- ☐ Cancer
- ☐ Mastectomy

- ☐ Arthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Gout
- ☐ Fibromyalgia/Chronic Pain
- ☐ Anxiety/Depression
- ☐ Sleep Problems
- ☐ Spinal Stimulator

- ☐ Severe or Frequent Headaches
- ☐ Visual or Hearing Difficulties
- ☐ Dizziness or Fainting
- ☐ Epilepsy/Seizures
- ☐ Bowel or Bladder Problems/Weakness
- ☐ Weight Loss or Gain/Fatigue
- ☐ Difficulty Swallowing
- ☐ Drooping Eye Lid

- ☐ Hernia
- ☐ Are Pregnant
- ☐ Hysterectomy
- ☐ Nausea/Vomiting

- ☐ Any pins or metal implants
- ☐ Shoulder Injury or Surgery
- ☐ Neck Injury or Surgery
- ☐ Joint Replacement Surgery
- ☐ Elbow/Hand Injury or Surgery
- ☐ Back Injury or Surgery
- ☐ Knee Injury or Surgery
- ☐ Leg/Ankle Injury or Surgery

- ☐ Recent Trips or Falls

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MEDICAL HISTORY

Please elaborate on any major medical condition checked above:

_____

_____

Please list any other medical conditions, surgery, or information you'd like us to know:

_____

_____

Please list all current medications or provide us a copy:

_____

_____

Have you had any of the following Medical Treatments or Testing:

- ☐ Physical Therapy
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Massage
- ☐ Emergency Room Care
- ☐ X-Ray
- ☐ CT Scan
- ☐ MRI
- ☐ Bone Scan
- ☐ Ultrasound

Please elaborate on the outcome of your treatment or testing if checked above:

_____

_____

What is your biggest question or concern regarding your pain or injury for our therapists to address today:

_____

_____

I certify that the above personal and medical information is complete and accurate to the best of my knowledge. I understand and agree to the Consent To Be Recorded and Consent For Treatment.

_____ _____

SIGNATURE DATE

_____ _____

PARENT OR GUARDIAN (IF MINOR) DATE

CLEARCUT ORTHO, LLC
POLICIES AND CONSENTS

CONSENT TO RELEASE/ OBTAIN MEDICAL INFORMATION:

Permission is hereby granted to ClearCut ORTHO, LLC to release any and all pertinent PHI information to me, my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. **Permission is hereby granted to any facility where I have previously been treated to release medical records to ClearCut ORTHO, LLC.**

Please list below any other individuals you would like to have authorization to access your information:
Name:_____ Relationship:_____ DOB:___/___/_____

FINANCIAL POLICY STATEMENT:

I authorize ClearCut ORTHO, LLC to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although ClearCut ORTHO, LLC will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold ClearCut ORTHO, LLC responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me. We have prepared a detailed **FINANCIAL POLICY STATEMENT** to help you better understand our policies in regards to your personal health information. The terms of the Financial Statement may change with time and we will always post the current notice at our facility, on our website and have copies available for distribution. The undersigned acknowledges receipt and understanding of this information.

INFORMATION PRIVACY STATEMENT:

ClearCut ORTHO, LLC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. The terms of the Privacy Statement may change with time and we will always post the current notice at our facility, on our website and have copies available for distribution. The undersigned acknowledges receipt and understanding of this information.

CONSENT TO BE RECORDED:

I hereby give my permission for ClearCut ORTHO, LLC to videotape or photograph me performing exercises or movements on any company device or on my own personal devices. I understand that all pictures or videos on company devices are considered private HIPAA protected information and will not be used in any means or format without written consent from the patient. Recordings on company devices may be to give feedback on biomechanics and movement patterns. Many times the patient uses the recordings on their own cellular devices to enhance understanding of their home exercise program.

I understand that I may decline recordings at any time.

CONSENT FOR TREATMENT:

I consent and authorize ClearCut ORTHO, LLC to provide physical therapy services to myself or my dependent, that may be considered appropriate upon the professional judgment of my treating therapist, and/or my referring physician. I also understand that I have the right to ask, and have any questions answered prior to, during, and after treatments. This includes risks, benefits, alternatives, and purpose of treatments. I understand that under the supervision of my physical therapist, treatment may include; electrical stimulation, dry needling, spinal manipulation, ultrasound, laser treatment, joint mobilizations, therapeutic exercise, moist heat, iontophoresis, traction, ice, paraffin, soft tissue mobilization, neuromuscular re-education, and the use of an anti-gravity treadmill. I understand that my physical therapist will utilize such interventions as he/she deems appropriate to my care.

I understand and agree to the Consent To Release/Obtain Medical Information, Financial Policy Statement, Information Privacy Statement, Consent To Be Recorded, and Consent For Treatment statements above.
I acknowledge that I have received copies of the Financial Policy and Privacy Policy:

_____ _____
SIGNATURE DATE

_____ _____
PARENT OR GAURDIAN (IF MINOR) DATE

CLEARCUT ORTHO, LLC
CANCELLATION / NO-SHOW POLICY

The no-show/cancellation policy is enforced for the following reasons:

1. We rely heavily on our schedule to maintain a high standard of care.
2. By giving appropriate notice to the facility, we are able to offer your appointment slot to other patients.
3. Repeated cancellations will slow your progress and likely prevent you from experiencing optimal outcomes from treatment.

Appointment times scheduled with ClearCut ORTHO, LLC represent time set aside specifically for you as a patient. All cancellations must be made at least 24 hours prior to the scheduled visit except in case of illness or emergency. Patients who cancel or no show on three separate occasions will be allowed to schedule additional appointments only at the discretion of the treating therapist.

By law, all cancellations and no shows involving **worker's compensation** claims must be reported to your physician and your claims adjuster. This will negatively affect your case and physical progress in physical therapy.

All Cancellations (less than 24 hour notice) and No-Call/ No-show appointments will be billed a charge of **$20.00** to your home address.

REPEATED CANCELLATIONS

Your therapist will recommend a frequency of treatment based on your specific needs. Optimal outcomes from treatment can only be achieved if you take responsibility in your care and are compliant with the therapist's recommendations. Repeated cancellations may result in you being discharged for noncompliance.

A copy of these policies will be provided upon request.

_____ _____

Name Date

ClearCut® ORTHO

DRY NEEDLING CONSENT & INFORMATION FORM

What is Dry Needling?

Dry Needling is a form of therapy in which fine needles 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 Chines meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and 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 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 event (1 in 200,000).

Is there anything your practitioner needs to know?

1. **Have you ever fainted or experienced 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 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 infections disease?** **YES / NO**
10. **Have you eaten in the last two hours?** **YES / NO**

- **Only single-use, disposable needles are used in this 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: _____ Date: _____

CLEARCUT ORTHO, LLC
FINANCIAL AND BILLING POLICY

At ClearCut ORTHO, LLC (herein referred to as "CCO") we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required, the severity and complexity of the injury or illness, as well as the time spent treating you. The patient or responsible party is responsible for seeing that the entire bill is paid in full. CCO is contractually obligated to collect on balances that are the patient's responsibility. Your clear understanding of our Financial Policy is important to our professional relationship.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Our professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. Therefore, if your insurance does not respond within 30 days the bill will become your responsibility. Please notify us if your insurance carrier or policy has changed.

Copayments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay at each visit.

Deductibles and Co-Insurance: CCO will verify your insurance benefits and you will be expected to pay your deductible amounts prior to services being rendered. If you have questions regarding any amount due after insurance has processed your claim, please contact them (your insurance) directly.

Non-Covered Services: If your insurance plan determines that a service is not covered for any reason, you will be responsible for payment of the charges. If your insurance requires authorization, and they advise CCO that authorization is NOT required, we can only go by what the insurance tells us. It will be your responsibility to pay for all rendered services, regardless of you insurance's choice to cover or not cover. CCO will do everything in our power to be sure proper authorization and visit limitations are monitored and adhered to, but sometimes insurances tell us one thing, then do something else, and this is not the responsibility of AOPT, rather it is the responsibility of the patient first and foremost.

Non-Participating Insurance Plans or "Out of Network": It is the responsibility of the patient to verify whether CCO contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ.

Referrals: All patients require a referral from an appropriate provider (physician, physician assistant, nurse practitioner, etc) it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule.

Workers Compensation/Other Accident Cases: In order for CCO to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information, we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. CCO will not bill attorneys for medical services.

Self-Pay/Uninsured: Payment in full is required for all self-pay/uninsured patients. For new patients, $100 per visit for Physical Therapy services payed at time of service will be required. Any fees remaining will be collected following your appointment at check-out.

CLEARCUT ORTHO, LLC
NOTICE OF PRIVACY PRACTICE
PAGE 1

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

The terms of this Notice of Privacy Practices apply to ClearCut ORTHO, LLC and its entities. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by ClearCut ORTHO, LLC.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke the authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosure for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and other professionals involved in your care will use information in your medical record and information you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Options: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved in Your Care: With your written agreement, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to the Owner at ClearCut ORTHO, LLC, 1001 12th Ave #201, Fort Worth, TX, 76104.

CLEARCUT ORTHO, LLC
NOTICE OF PRIVACY PRACTICE
PAGE 2

Other Uses and Disclosures:
We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law
- Public health activities, such as required reporting of disease, injury, death, or required public health investigations
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls
- To your employer when we have provided healthcare to you at the request of your employer
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings
- Court or administrative ordered subpoena or discovery request
- To law enforcement officials as required by law to report wounds and injuries and crime
- If you are a member of the military, we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU MAY HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION: Access to Your Personal Health Information
You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from our front office. You are entitled to one free copy of your personal health information. If you request additional copies, you may be charged a nominal fee for copying and postage.

Amendments to Your Personal Health Information
You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments, but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/ correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the Owner.

Accounting for Disclosures of Your Personal Health Information
You have the right to receive an accounting of certain disclosures made by us of your personal health information after October 12, 2013. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the Owner(s). The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or healthcare operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such notice to the Owner.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing to the Owner, ClearCut ORTHO, LLC, 1001 12th Ave #201, Fort Worth, TX, 76104. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact the Owner, ClearCut ORTHO, LLC, 1001 12th Ave #201, Fort Worth, TX, 76104; 817.719.7714.