MEDICATION LIST

Patient Name: _____

Use the chart below to list all **brand-name** and **generic prescription** medications you currently take. Please also include any **over-the-counter vitamins/supplements**. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the label in milligrams (mg). This is called the dose, or strength. The label on liquids and shots lists the dose. Please notify your PT of any changes in this list.

Medication/Vitamin Name	**Dose** (such as 2 mg, 1tsp)	**Method**	**How Often** (such as 3x/day)

The above medications have been discussed and reviewed with the patient by their PT at 1st Visit:

Physical Therapist Signature: _____ Date: _____

The above medications have been discussed and reviewed with the patient by their PT at re-evaluation or 10th visit:

Physical Therapist Signature: _____ Date: _____

Medicare Notice

Effective January 1, 2025 Medicare has changed the coverage of Physical Therapy/Occupational Therapy services delivered in an outpatient setting. The Part B deductible is now $257 per calendar year. Medicare covers only certain procedures and therefore may not cover all of your healthcare costs.

- **Medicare pays 80% of the allowed amount and the beneficiary pays 20% up to $2,410.00, at which point your Physical Therapist/Occupational Therapist must justify medical necessity. Therapy services beyond $3,000 per calendar year are subject to medical review.**

- **Medicare will not pay for both home health care and outpatient therapy simultaneously.**

_____ I certify that I currently do not have home health care/have been discharged from any previous home health care treatments.

This form acknowledges that you are aware of the fact that you may be held financially responsible should Medicare not pay for your Physical/Occupational Therapy expenses. At some point in your treatment, you may be required to sign an ABN form. As you progress in your treatment, you, your therapist and your physician must prove medical necessity to Medicare in order to continue treatment.

_____ _____

Signature of Beneficiary **Date**

ENDURANCE REHABILITATION

Patient History

Name: _____ Preferred Name:_____

Date: _____Age: _____ Height: _____ Weight: _____

E-Mail Address: _____

How would you prefer your therapist to contact you? EMAIL PHONE

Would you like appointment email reminders? ***YES NO***

**All home exercise programs will be emailed*

Have you had physical therapy before? YES NO

How did you hear about Endurance Rehab?

- ☐ Internet
- ☐ Friend: _____
- ☐ Sport Club: _____
- ☐ Other: _____
- ☐ Insurance
- ☐ Physician: _____
- ☐ Store: _____

Did a physician refer you for this injury? YES NO If yes, who? : _____

If yes, when is your next follow-up appointment? _____

Main complaints/symptoms: _____

_____

Pain Level: At best: ____/10; At worst: ____/10 (0=no pain, 10= worst/maximal pain)

What intensifies the pain? _____

What alleviates your pain? _____

When did problem begin? _____

List functional limitations/difficulties (tasks during the day at home, work or recreationally)

1. _____ 2. _____ 3. _____

Was this an accident or work related injury? If so, date of accident/injury; describe what happened and where. _____

_____

Have you had this or similar symptoms before? YES NO If yes, please describe:

_____

_____

Please list past surgeries, including minor:

Surgery: Date:

_____

_____

_____

ENDURANCE REHABILITATION

Patient name: _____ Date: _____

Please check any conditions/symptoms listed below that you have had in the past or are currently experiencing:

- ☐ Thyroid problems
- ☐ Hernia
- ☐ Cancer
- ☐ Headaches
- ☐ Migraines
- ☐ Neck stiffness
- ☐ Muscle spasms
- ☐ Muscle cramps
- ☐ Painful joints
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Multiple sclerosis
- ☐ Chills
- ☐ Weakness
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fainting
- ☐ Seizures/Epilepsy
- ☐ Facial pain/numbness
- ☐ Vision deficits
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Jaw pain
- ☐ Heat/cold intolerance
- ☐ Poor wound healing
- ☐ Diabetes
- ☐ Circulation problems
- ☐ Kidney problems
- ☐ UTI
- ☐ Asthma
- ☐ Emphysema
- ☐ Pain when breathing
- ☐ Shortness of breath
- ☐ Angina
- ☐ Heart attack
- ☐ High Blood pressure
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Abnormal Heart beat
- ☐ Stroke
- ☐ Anemia
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of sleep
- ☐ Allergies

For any of the above conditions/symptoms that you marked, please explain:

_____

_____

_____

Please list any medications you are taking:

_____

_____

_____

Are you allergic to latex? YES NO
Are you taking a blood thinner? YES NO
Do you smoke? YES NO

FEMALES
Could you be or are you pregnant? YES NO

I attest that the information provided above is true:

Patient signature: _____ **Date:** _____

Patient Rights & Responsibilities
Consent For Treatment Medical Release

I, _____, hereby authorize Endurance Rehabilitation and/or its licensed medical professionals and such assistants to render any and all medical care deemed necessary and any additional care and supplies that are recommended.

Cancellation/No Show Policy
When canceling your appointment due to scheduling conflicts we ask that you please do so by 4:00pm the business day prior. We keep a waiting list of patients that would like to have your spot if it is available. If you are unable to cancel your appointment by 4:00 pm the prior business day, or if you are unable to make your appointment and do call us, you will be charged a $25 fee. Also, a $25 fee will be charged to your account if you no show/no call to one of your appointments.

Medical Record Release
This will authorize Endurance Rehabilitation to release any general, medical, as well as Psychiatric/Psychological, drug/alcohol, and HIV testing information from my health records, per patient's request.

Third Party Liability
Endurance Rehabilitation does not believe that a liability case against a third party is reason to delay payment of services. I agree that payment for services rendered is not contingent upon any settlement, judgment, or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered.

Assignment of Benefits
I authorize Endurance Rehabilitation to process claims related to my personal health or other insurance for covered services rendered to me. I also assign and authorize payment from said insurance carrier to be paid directly to Endurance Rehabilitation rendered on my behalf.

Circumstantial Risk
I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognize that I am free to seek other opinions relating to my health.

Financial Obligation
Endurance Rehabilitation requires that all co-pays, co-insurances and deductibles be paid at the time of service. Failure to maintain a current patient account may result in the placement of your account with an outside agency for Collection.

I have reviewed and understand the Patient History, Patient Rights & Responsibilities, Consent For Treatment, Financial Responsibility, Medical Release, Cancellation/No Show Policy, and HIPAA Privacy Notice. A copy of the aforementioned paperwork will be provided upon request.

Print Patient's Name: _____

_____ _____

Patient or Parent/Guardian Signature **Date**

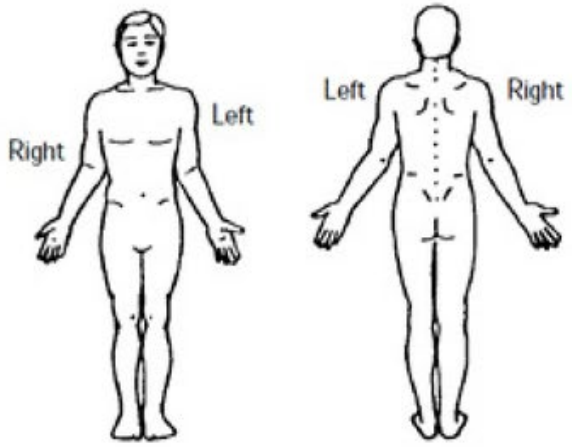
Date: _____ /_____ /_____ Time: _____

Name: _____ _____ _____
Last First Middle intial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on **average**.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10	20	30	40	50	60	70	80	90	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:

A. General activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

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 Chinese 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 in 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, 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 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. Aspirin, Warfarin, or 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, C, HIV, or any other infectious disease? YES / NO
10. Have you eaten in the last two hours? YES / NO

Single-use, disposable needles are used in this clinic.

Endurance Rehabilitation requests that payment be collected at each visit. Insurance does not pay for this service.

- **Dry Needling with Physical Therapy - $30**
- **Dry Needling without therapy - $80**
- **Dry Needling without therapy – 10/$750**

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.

Printed Name: _____

Signature: _____ Date: _____

Special Consent to FDA Approved "Erchonia Low-Level Laser" for demonstration laser application.

Patient's Name: _____ Date: _____

Clinic Name: _____Endurance Rehabilitation_____

The Erchonia Low Level Lasers offer a new clinically proven treatment option that is safe, effective and cleared by the FDA for the treatment of:

- Chronic Neck Pain
- Chronic Shoulder Pain
- Chronic Low Back Pain
- Post-Operative Pain
- Heel Pain related to Plantar Fasciitis

Low Level laser therapy is a painless, sterile, non-invasive, drug free modality that is used for a variety of conditions such as acute and chronic pain, body contouring, acne and appearance of cellulite.

Endurance Rehabilitation requests that payment be collected at each visit. Insurance does not pay for this service.

Single laser treatment - $30 / session

Discounted package - $250 for 10 sessions

Patient's Acknowledgement

I acknowledge that I am not pregnant: _____

I acknowledge that I do not have a pacemaker: _____

I acknowledge that I would like a laser demonstration today (if therapist recommends): _____

I acknowledge that I have read (or have had read to me) and fully understand the above consent, the explanations referred to above were complete and all blanks, if any, were filled in before I affixed my signature.

Patient or Patient's Representative Signature:_____ **Date**:_____

****YOU DO HAVE THE OPTION TO DECLINE OR REQUEST MORE INFORMATION. PLEASE CHECK THE BOX BELOW IF YOU WOULD PREFER ONE OF THESE OPTIONS****

☐ **DECLINE LASER (You can change your mind at any time)**

☐ **PLEASE HAVE THE THERAPIST GIVE ME MORE INFORMATION ABOUT LASER TREAMENT**

Initials _____