Patient Registration Form

Symmetry Physical Therapy
One-on-one patient care
28 W. Flagler St. Suite 901
Miami, FL 33130
Phone: 305.331.2277
Fax: 305.424.9361
admin@ptmiami.com
SymmetryPTmiami

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Email:** _____

Home Phone # _____ **Work Phone #** _____

Mailing Address: _____

_____

Emergency Contact: _____ **Phone #**_____

Relationship: _____

How did you hear about us?

____☐ Google ____☐ Previous Patient ____☐ Physician ____☐ Social Media _____☐ _____Other

Do you have a written prescription? Yes_____☐ No_____☐

Prescribing MD: _____

Was this injury the result of an accident?

_____☐ NO _____☐ Work _____☐ Auto _____☐ _____Other

Attorney Name: _____ **Phone #**_____

Adjuster Name: _____ **Phone #**_____

Case #_____

Authorization to Release/Obtain Information

I hereby authorize the release of any and all information to my insurance company or other appropriate part, as required, pertaining to treatment rendered to me by Symmetry Physical Therapy. Further, I authorize Symmetry Physical Therapy to obtain needed information from my physician, employer, or insurance company.

Consent to Treatment and Financial Responsibility

I hereby understand and fully agree that (regardless of my insurance status) I am ultimately responsible for any balance owed to Symmetry Physical Therapy (Natalia Sikaczowski, DPT) for any medical services rendered to me, including any unfulfilled deductible amount and/or coinsurance on my insurance plan. I also understand that any balance not paid after 30 days will be charged finance fees as allowed per state (% subject to change). Furthermore, I also understand that should my account be transferred to a collections agency or attorney for collective action, I will be responsible for the principal amount and any collection fees, if any. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I do hereby consent to such treatment by the authorized personnel of Symmetry Physical Therapy. This content is intended as a waiver of liability for such treatment except for negligence.

If a patient is a minor parent must sign this form and consent to treatment. Otherwise, services cannot be rendered by State Laws. I have read and understood all the above and I certify that this information is true and correct to the best of my knowledge. Also, I will notify Symmetry Physical Therapy if any of the above information changes during my treatment.

ATTENTION CIGNA PATIENTS ONLY: Your insurance provider has contracted a 3rd party company known as American Specialty Health (ASH), to verify medical necessity. Please advise that American Specialty Health determination of medical necessity supersedes your plan benefits and eligibility. Therefore, ASH can approve and deny visits at their discretion. Should your physical therapy session(s) be determined as non-medically necessary, you will be financially responsible for all medical services rendered. This determination varies by plan. It is recommended that you contact your insurance to verify your plan benefits and covered services.

Notice of Information Practices

I acknowledge that I have been shown the posted notice of information practices by Symmetry Physical Therapy.

_____ _____

Signature of Patient or Parent/Guardian **Date**

Payment Policies

To make the cost of your care as easy and manageable as possible, we offer several payment options. You can choose to pay by cash, check, or major credit card. All transactions will be charged on Mondays for the previous week's balance.

By Check: Please make checks payable to Symmetry Physical Therapy. There is a $30 charge for returned checks. ***Cash:*** Please ask for receipt if needed ***Credit Card:*** Will be charged on Monday for the previous weeks' balance. A credit card on file is required for weekly payments. All credit card transactions will have a 3.5% pass through fee.

CANCELLATION POLICY

As a small privately-owned company, it is extremely important to us that we maintain the highest level of service and quality care. To commit and reserve one hour of the doctor's time with each patient, we must enforce a strict cancellation policy.

A $75 charge will be incurred if 24 hours notice is not given
A $165 charge will be incurred for all no shows OR cancellations within 5 hours of the appointment

No Exceptions

Please do NOT text the automated appointment reminder message. Texts are not received on any number except the office line 305-331-2277.

X_____ (Initial here) ***I have read and agree to the cancellation policy***

As a small business that depends on consistency of treatment to maintain one-on-one quality care we thank you for your understanding!

Credit Card on File Information:

Name on CC: _____

Type: Visa ☐ MasterCard ☐ AMEX ☐ HSA ☐

Credit/Debit Card #_____ **Expiration Date:** _____

CVV #_____

CC billing address zip code: _____

Credit card information gets scanned into our billing department, stored in a secure processing system and then ***blacked out****.*

My signature below constitutes an authorization to charge my credit card as indicated and that I have read and

understood Symmetry Physical Therapy's payment policies.

_____	_____	_____
Patient's Name (Print)	**Patient's Signature or Legal Guardian**	**Date**

Symmetry Physical Therapy
One-on-one patient care

DRY NEEDLING INFORMATION & CONSENT 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 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 flow of energy ("Qi"- pronounced chee) 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, and low back pain.

Is Dry Needling Safe?

- **Single-Use, Disposable Needles ARE Used in this Clinic!!**
- Drowsiness, tiredness, and/ or dizziness may occur after treatment in a small number of patients (1-3%). If this occurs, you are advised not to drive and to have a driver pick you up.
- Minor bleeding or bruising can occur after treatment (15-20% of patients) and is considered NORMAL.
- Temporary pain occurs during dry needling in 60-70% of treatments. Existing symptoms can get worse after treatments (< 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 of the head/ neck is performed.
- Dry needling is very safe; HOWEVER, serious side effects can occur in less than 1 per 10,000 (< 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:
        - o Shortness of breath on exertion
        - o Increased breathing rate
        - o Chest pain
        - o A dry cough
        - o Bluish discoloration of the skin
        - o 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 blood thinners (e.g., aspirin, 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 infectious disease? YES NO
10. Have you eaten in the last two hours? YES NO

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 of Client Date

Medical History Form

Area of Symptoms: _____

Date of injury / onset: _____

Have you ever had physical therapy for these symptoms before? ☐ **Yes** ☐ **No**

Have you had any x-rays/ MRI/ CT Scan? _____

How many days since your current injury 0-30 ☐ **31-90** ☐ **90+** ☐

Have you had a related surgery? ☐ **Yes** ☐ **No**

Please check if you currently have or have had any of the following:

- ☐ Allergies to Aspirin
- ☐ Diabetes
- ☐ Chest / Angina
- ☐ Allergies to Heat
- ☐ High Blood Pressure
- ☐ Poor tolerance to Cold
- ☐ Heart Disease
- ☐ Other Allergies
- ☐ Heart Attack
- ☐ Hernia
- ☐ Heart Palpitation
- ☐ Seizures
- ☐ Pacemaker
- ☐ Metal Implants
- ☐ Headaches
- ☐ Dizziness / Fainting
- ☐ Kidney Problems
- ☐ Recent Fracture
- ☐ Pregnant
- ☐ Surgeries
- ☐ Cancer
- ☐ Skin Abnormalities
- ☐ Osteoporosis
- ☐ Sexual Dysfunction
- ☐ Bowel / Bladder Abnormalities
- ☐ Nausea/ Vomiting
- ☐ Urine Leakage
- ☐ Ringing in your ears
- ☐ Asthma / Breathing Difficulties
- ☐ Rheumatoid Arthritis
- ☐ Liver / Gallbladder Problems
- ☐ Special Diet Guidelines
- ☐ Smoking
- ☐ Hypoglycemia

Please list any current medications:

_____

How would you rate your ability to perform routine daily activities?

0%☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%☐

How would you rate your ability to perform activities associated with your job?

0%☐ 10%☐ 20% ☐30%☐ 40%☐ 50%☐ 60% ☐70% ☐80% ☐90% ☐100%☐

How would you rate your current pain?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

None Emergency Room

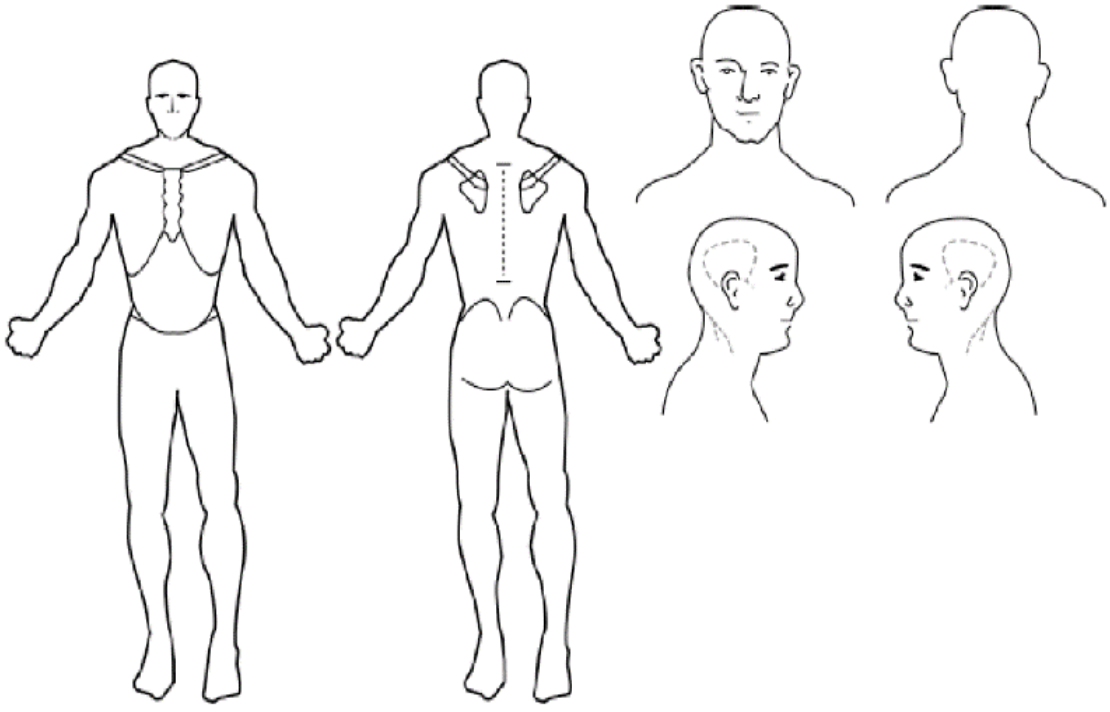
Please draw your pain on the body below:

/// Stabbing Pain

xx Burning

ooo Pins and needles

=== Numbness



_____ _____

Patient or Parent Guardian Signature Date

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One-on-one patient care

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admin@ptmiami.com

Location:
We are located at 28 W. Flagler St., inside of the Courthouse Plaza Building, across from the Federal Courthouse.

Validated Parking:

Pro Park is located at 35 SW 1st St, the garage is attached to the Courthouse Plaza Building (in the rear) and is **$4 for the day**. There is a direct entrance into the building from the Pro Park garage. Once you park, take the elevator to the 2nd floor of the garage, the entrance to the building will be on your right (Brown Doors).

Pro Park Hours:
Monday through Friday: 6am to 9pm
Saturday Parking: 9am to 7pm

Metrorail:
Located near the Government Center Station.

Metro mover:
Located near the Government Center Station which can be accessed from the OMNI loop, Brickell loop and Downtown Loop.

The Miami Ave stop on the Inner loop is a half block away from the clinic