PINAMONTI
physical therapy and wellness center

DRY NEEDLING PATIENT REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Address:	City:	State: Zip:
Home Phone:	Cell:	Email:
Date of Birth: Sex:	Marital Status:	
Employer:		Work Phone Number:
Emergency Contact:	Phone Number:	Relationship:

Referring Doctor (if referred):	Primary Care Doctor:
Date of Onset of Symptoms:	Physical Therapy is for treatment of:

How did you hear about Pinamonti Physical Therapy? (Circle one - if "Other" please specify)

Doctor Friend/Relative Radio Print TV Internet Phone Book Employer Other _____

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Dry Needling Informed Consent

Please review the following information PRIOR to consenting to being treated with dry needling techniques, as recommended by your physical therapist or physician as part of your plan of care.

Dry needling administered by a physical therapist is not the same as acupuncture, however, it is a technique that utilizes similar thin, solid filament needles. The dry needling technique is used specifically to treat myofascial trigger points, muscle spasms, scars, or other areas with tight tissues. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure. If you are pregnant, use anti-coagulant medications (blood thinners), or have any cosmetic implants, please notify your physical therapist prior to dry needling. Please check the appropriate box:

□ I am pregnant; □I am taking blood thinners; □I have (cosmetic) implants: _____

- Pain. When a needle is inserted in the correct location, it may briefly reproduce a muscular ache or a twitching response, which usually indicates that the technique will be effective in reducing your symptom. You may experience a muscular ache for one or two days, similar to the ache after working out, followed by an expected improvement in your overall symptoms. It is important that you share with your physical therapist if you are feeling uncomfortable with the treatment.
- Infection. Any form of skin penetration creates an opportunity for bacteria to enter the system. In order to minimize the risk, your physical therapist will only use sterile disposable single-use needles. There are no reliable reported cases of infection in the medical literature due to dry needling.
- Bruising or Bleeding. On occasion you may experience minimal bruising or bleeding.
- Pneumothorax (collapsed lung). Pneumothorax is a serious medical condition that can occur when a needle is placed too deep into the lining that covers the lungs. The diagnosis is made with an x-ray or with sonography. Your physical therapist has been trained to avoid the lungs and limit needle depth to avoid a pneumothorax.
- Epidural hematoma (bleeding in the spinal canal). When needling near the spine, there is a small risk of causing a bleed in the so-called epidural region. Worldwide there are less than 10 reported cases in the acupuncture and dry needling literature. Your physical therapist has been trained to avoid this complication.
- Drowsiness, fatigue and autonomic responses. On occasion you may experience a feeling of tiredness, nausea, dizziness, or sweating. If this occurs, you may be asked to avoid driving until the feeling has passed. Changes in blood pressure, heart rate, flushing of the face or breathing rate are involuntary reflexes, which may occur occasionally as a result of dry needling without cause for concern.

I have read this form and I understand the risks involved with dry needling therapy. I have had the opportunity to ask questions and express any concerns, which have been answered to my satisfaction. I also agree to advise my physical therapist of any and all changes in my physical condition whether or not I believe these changes will affect my treatment or plan of care.

With my signature, I hereby consent to the performance of dry needling provided by my physical therapist.

Print Name:_____

Signature: _____ Date: _____

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Privacy Notice

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

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your physician, orthopedic surgeon etc.) in connection with our rendering physical therapy treatment to you (i.e., to determine the appropriate plan of care, treatment etc.);

- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

- To certifying, licensing and accrediting bodies (i.e., the Kansas State Board of Healing Arts, etc.) in connection with obtaining certification, licensure or accreditation;

- Internally, to all staff members who have any role in your treatment;

- To your family and close friends involved in your treatment; and/or,

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- We may mail appointment reminders in postcard form, leave messages about appointments on answering machines, which may be read or overheard by others.

- We may use or disclose your health information when we are required to do so by law.

- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

-continued-

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.
Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

You may refuse to Sign This Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____
Patient or Guardian Signature: Date:

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communications barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other _____