Client Agreement Form

1. **Consent to Treat**: ***I realize I have the right to refuse any treatments or procedures.*** You have been diagnosed as having a muscle disorder that might benefit from dry needling therapy. Research and practice shows that dry needling can lessen muscle pain and reduce muscle tension. Dry needling therapy is not acupuncture, but it is similar to it in the sense that needles are introduced into the tissues for therapeutic reasons. The physical therapist will be inserting the needles in places in your muscles that are causing your discomfort (trigger points), not in areas that are far away from your pain (distal points) or on your ear (auricular points). THE POSSIBLE RISKS OF DRY NEEDLING INCLUDE, BUT ARE NOT NECESSARILY LIMITED TO, THE FOLLOWING: PUNCTURED LUNGS, BRUISING, INFECTION, EXTENDED OR TEMPORARY NERVE INJURY, TEMPORARY MUSCLE SORENESS, OR INJURY TO BLOOD VESSELS CAUSING A POOLING OF BLOOD IN YOUR TISSUES. ***I realize I have the right to refuse any treatments or procedures.*** Alternative therapies that could be used instead of dry needling include, but are not necessarily limited to, the following: traditional physical therapy techniques such as manual therapy, ultrasound, electrical stimulation, therapeutic activities, neuromuscular re-education and therapeutic exercise. I HAVE READ THE ABOVE INFORMATION, THE NATURE AND PURPOSE OF THE PROCEDURE, POSSIBLE ALTERNATIVE METHODS OF TREATMENT, RISKS INVOLVED, AND THE POSSIBILITY OF COMPLICATIONS HAVE BEEN FULLY EXPLAINED TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS THAT I HAVE ABOUT DRY NEEDLING THERAPY. NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED. I HEREBY AUTHORIZE MY PHYSICAL THERAPIST(S) TO PROVIDE ME WITH DRY NEEDLING THERAPY. I have presented myself to this facility for physical therapy treatments and I give consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist. I acknowledge that the delivery of healthcare does not guarantee results of any treatments at this facility. I do hereby consent to such treatment by the authorized personnel of Renew PhysioTherapy, LLC as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment.

_____ (Initials)

2. **Payment for Services**: An insurance policy is a contract between the patient and the patient's insurance company. As a courtesy, Renew PhysioTherapy, LLC will submit PT service claims to your insurance company. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. If your insurance company does not pay for all services rendered then the patient/guardian will be responsible for unpaid balances for services. I agree to pay for remaining balance unpaid by my insurance. I understand that if my plan does not pay for services provided by Renew PhysioTherapy, LLC I am responsible for full payment.

_____ (Initials)

3. **Privacy Practices**: PATIENT PRIVACY NOTICE THE FOLLOWING ABBREVIATED NOTICE BRIEFLY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE UNUSED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU. Renew Physiotherapy abides by current Code of Alabama Sect 12-21-6.1 and US Department Health & Human Services Legislation HHS 45 CFR 164.524-1. For Treatment: Renew Physiotherapy, LLC may use health information about you to provide you with health care treatment or services. We may disclose health information about you to personnel who are involved in taking care of you. For Payment: We may use and disclose health information about you so that the services you receive from us may be billed to insurance carriers and payment collected. For Health Care Operations: We may use and disclose health information about you for operations that are necessary to run our practice. Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

(over)

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs. Workers' Compensation: We may release health information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses. Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order, etc. Law Enforcement: We may release health information if asked to do so by a law enforcement official. RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. I grant Renew Physiotherapy permission to communicate my healthcare information with me via phone, phone message, text, and/or email.

_____ (Initials)

I, the undersigned, have read and fully understand the above information. *All of my questions have been answered fully*.

Patient Name (print): _____

Patient Signature:_____

Date: _____

Guardian Name (print):_____

Guardian Signature: _____

_____

Witness name Witness signature Date

Emergency Contact

Name: _____

Phone Number: _____