FOUR SEASONS
PHYSICAL THERAPY

New Core Wellness
Physical Therapy

Four Seasons Physical Therapy PC, New Core Wellness Physical Therapy PC, Taeyong Kim Acupuncture PC

Patient Registration (Please Fill-Out Form Completely & Legibly)

Last Name _____ First Name _____ Age ____ ☐ Male ☐ Female

Street Address _____ City _____ State ____ ZIP _____

Cellular _____ Home Phone _____ Email Address _____ ☐ Single ☐ Married

Emergency Contact person _____ Phone _____ Social Security _____ Date of Birth ____/____/____

Carry Insurance Name: _____

Aetna ( ) BCBS ( ) CIGNA ( ) Nippon life ( ) UHC ( )

etc:_____ Policy # (If you know)_____

Authorization To Release Information & Payment Request

Insurance billing:

I hereby authorize the release of any medical or other necessary information to my insurance company for claim processing. I also authorize the release of all information that my insurance company may request concerning my present and past illnesses or injuries.

Payments of Medical Benefits:

I hereby authorize payments of medical benefits to Four Seasons Physical Therapy PC, New Core Wellness Physical Therapy PC, Taeyong Kim Acupuncture PC for physical therapy, acupuncture services rendered to me while I was under their care. I understand that I am personally responsible for all charges associated with my treatments.

Authorization To Receive Physical Therapy Care

I give permission to Four Seasons Physical Therapy PC, New Core Wellness Physical Therapy PC, Taeyong Kim Acupuncture PC for a check-up (screening), physical therapy, acupuncture examination/evaluation, and for treatment. Treatment may consist of:
Modalities: Hot/Cold Packs, Cryotherapy (ice massage), Ultrasound/Phonophoresis, Diathermy, Electrical Stimulation/ Iontophoresis, Infrared, Whirlpool, Fluidotherapy, WCNE (ERT, APCT), Shockwave (ESWT),
Manual Therapy: Joint and Soft tissue mobilization, manual stretching / traction, intramuscular stimulation (IMS, dry needle technique), Acupuncture, etc. Therapeutic Exercises / Activities: Activities and exercises with and without equipment or any other appropriate treatments necessary for the patient. I have also been advised of the possible side effects of the treatment and consequences if I decide not to receive care. I understand that there is no guarantee for complete recovery.

I HAVE READ THE ABOVE PARAGRAPH AND I UNDERSTAND THE INFORMATION PROVIDED. THIS INFORMATION HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS ASKED HAVE BEEN ANSWERED TO MY SATISFACTION. I THEREFORE AUTHORIZE FOUR SEASONS PHYSICAL THERAPY PC, TO PROCEED WITH THE TREATMENT.

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General Consent For Treatment

1. **General Consent for Treatment:** I, Voluntary consent to and authorize such care and treatments, including but not limited to physical examinations, diagnostics tests and medical procedures, by employees and authorized agents of Four Seasons Physical Therapy, New Core Wellness Physical Therapy PC, **Taeyong Kim** Acupuc**nture PC** as may be considered necessary or advisable in their professional judgment. I further acknowledge that no guarantees have been made regarding the effect such treatments on any medical condition

2. **Right to Refuse Treatments:** I understand that I have the right to make informed decisions regarding all care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments I do not want.

3. I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to **Four Seasons** Physical Therapy, New **Core** Wellness Physical **Therapy** PC, **Taeyong Kim** Acupuncture **PC.** I acknowledge that I am financially responsible for payment whether or not covered by insurances.

4. Acknowledgment of Receipt of Notice of Privacy Practices. I acknowledge that I have received the Health Notice of Privacy Practices and acknowledge that this notice is available for me to keep.

5. **No Show & 24 Hour & Same day Cancellation Policy: Patient who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation"** fee and be charged if there is a same day cancellation.

By signing below, I Acknowledge that I have read, understand and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Representative to sign this document and be bound by its terms.

Acknowledgment Of Receipt Of Private Notice

By signing this form, you acknowledge that **Four** Seasons Physical Therapy, **New Core Wellness Physical Therapy** PC, **Four Seasons Physical Therapy PC, Taeyong Kim Acupuncture PC,** has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledge receipt of this notice as soon as we can after the emergency.

Check all that are true:

☐ I have received **Four** Seasons Physical Therapy, **New Core Wellness Physical Therapy** PC Privacy Notice

☐ **Four** Seasons Physical Therapy, **New Core Wellness Physical Therapy** PC has given me the chance to discuss my concerns and questions about the privacy of my health information

Signature_____ **Date**_____

Four Seasons Physical Therapy PC, **New Core Wellness Physical Therapy PC, Taeyong Kim Acupuncture PC** staff should complete if Acknowledgment Form is not signed

FOUR SEASONS
PHYSICAL THERAPY

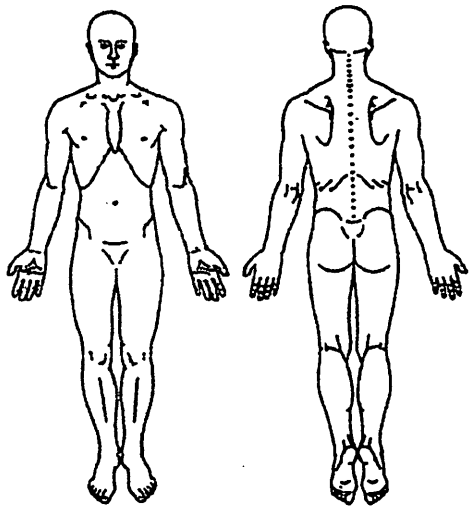
New Core Wellness
Physical Therapy

Patient History

1) What areas of the body (ie. Neck, L-Hip, R-Knee, etc.) or conditions (ie. Fibromyalgia, osteoarthrits, etc.) are you currently seeking physical therapy treatment for?

2) If there are multiple areas of involvement, which region/problem is of greatest concern at this time?

3) Have you been treated for this same problem before? Yes/No If yes, when & who treated this problem?



Shade your areas of pain and discomfort on the figures to the left:
Please rate your pain on the scale below from 0 to 10:
(0=no pain 10= worst pain)
Pain at rest: 0 1 2 3 4 5 6 7 8 9 10
Pain with activity: 0 1 2 3 4 5 6 7 8 9 10
What is the frequency of your pain? Constant Intermittent
Is your pain worse in the: AM PM Mid-Day

4) Current Level of Physical Activity: High Medium Low None List Activities (if any)

5) Please list all prescription medications you are taking, reason for medication (ie: Prozac for depression), Frequency (ie:3 times a day), and Root of Administration (ie: oral). Attach list if needed.

_____

_____

Medical History (Please circle any that apply past or present):

Cardiovascular Disease	Asthma/Breathing Difficulty	Hepatitis/Liver Disease	Depression
High Blood Pressure	Congestive Heart Failure	Epilepsy/Seizures	Anemia
Diabetes (I or II)	Multiple Sclerosis	Thyroid Condition	Osteoporosis
Stroke or Heart Attack	Fibromyalgia	Neurological Condition	Chronic Infections
Arthritis (Osteo/Rheum)	Migraines/Headaches	Eating Disorder	Lupus
Kidney/Renal Disease	Dizzy/Vertigo	Drug/Alcohol Abuse	HIV/AIDS

Cancer - Type: Location(s):_____Year:_____Status: _____

Other:_____

6) Do you have a pacemaker, internal defibrillator, insulin pump, metal fixator or any other implanted medical device(s)?

7) Are you currently pregnant or is there even a possibility you may be pregnant? Yes / No If Yes, how many weeks pregnant are you?

HIPAA CONSENT FORM

I give **Four Seasons Physical Therapy PC, New Core Wellness Physical Therapy PC, Taeyong Kim Acupuncture PC** my consent to disclose **my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews**. I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the clinic is not required to agree to the request. If the clinic agrees to my requested restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed. With this consent, **Four Seasons Physical Therapy PC, New Core Wellness Physical Therapy PC, Taeyong Kim Acupuncture PC** may call my home or other alternative phone numbers and leave a message on voice mail or to any person answering the phone in reference to any items that assist the office in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

Patient Name: _____Signature: _____Date: _____

parent, or **legal guardian** If signed by patient representative, state relationship to

Patient Name: _____Signature: _____Date: _____

Informed Consent for Physical Therapy Service

Physical Therapy (PT) is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability. The purpose of Physical Therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, therapeutic manual therapy technic, therapeutic exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. Response to Physical Therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol.

New Core Wellness Physical Therapy P.C, Four Seasons Physical Therapy P.C does not guarantee what your reaction will be to a specific treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during treatment, should you feel free of any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to understand the risks and benefits involved in your treatment. I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

No Show & 24 Hours Cancellation Policy: Patients who fail to show for the scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be charged or subject to a “No Show/Cancellation” fee.

Physical Therapist Name: Taeyong Kim DPT, L.Ac

Patient Name_____Signature_____Date_____

INFORMED CONSENT TO TREAT

Taeyong Kim Acupuncture P.C.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME:

ACUPUNCTURIST NAME: Taeyong Kim DPT, L.Ac

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)