New Beginnings Myofascial Therapy LLC

At Optimal Health and Performance 13 North Oak St Cookeville TN 38501

Sheri Brimm, P.T. Cell 931-319-0291 Office 931-651-1390 Fax 931-651-1391

INITIAL EVALUATION SUBJECTIVE REPORT TODAYS DATE:____________________

Date of Birth __________________ SS #______________________

Name____

Address ____

City __________________________State ___________ Zip _______________

Phone: CELL________________________________ Daytime Home or work___________________

Emergency Contact Name:_____________________________Phone:________________________

Contact E-mail: ____

Referring / Consulting Physician, Nurse Practioner, or Chiropractor

____

Address ___________________________________Phone ___________________________

Insurance provider____

Is your treatment related to auto or work accident? _______Yes _____No

Do you have Medicare or Medicaid primary or secondary? _____Yes ____No

PLEASE READ CAREFULLY: NO INSURANCE ACCEPTED OR BILLED

New Beginnings Myofascial Therapy LLC (NBMT) is a provider of physical and myofascial therapy. NBMT accepts payment by check, cash, or credit card at the time of service. Charges are currently at a rate of $100/hour and $25 for each additional 15 minutes thereafter.

NBMT Does not contract with any insurance companies, Medicare or TNCare. If you wish to seek physical or myofascial therapy that may be covered by your insurance Medicare, or TennCare, entirely, or in part, you will need to go to a different provider. You will need to work directly with your provider to determine whether services at their offices will be covered by your insurance. Local providers that may be contracted with your insurance company, Medicare, Tenncare, include but are not limited to: Cookeville Regional Medical Center, Cumberland Physical Therapy, Putnam Physical Therapy, TN therapy and balance center, Results, Star, Centers of development, Little hands Little feet.

NBMT does not do any direct billing and is not contracted with any insurance companies, if you qualify for self claims with your insurance, we can give you receipts with the codes. Your insurance may have a separate “out of network” deductible that needs to be met before you can get reimbursed. You are responsible for calling your insurance to pre-authorize treatment and to verify benefits. FYI (Medicare / TNCare generally cannot do self claims from non-providers)

IF YOU WISH TO BE REFERRED TO ANOTHER PROVIDER PLEASE INDICATE BELOW:

_________Initials: I Decline to continue with therapies at NBMT and wish to be referred to a provider that takes my insurance.

SIGNATURE____DATE______________

IF YOU WISH TO PROCEED, CONTINUE BELOW WITH CONSENT TO TREATMENT

INFORMED CONSENT: Due to Physical therapy direct access laws, NBMT has certain conditions where a physician must be consulted or informed of your care here.

LIST all problems for which you have received evaluation, surgery, or medical treatment by a physician, chiropractor, and/or PT in the past 12 months:

For which problems / complaints are you seeking treatment at this facility TODAY?

In the past 12 months, have you seen a licensed doctor of medicine, chiropractic, dentistry, podiatry, or osteopathy, for the condition complaint that you are here for? ____Yes____No

List name / address / phone number of the doctor/provider you saw for the current complaint

Were you referred to NBMT by a licensed doctor of medicine, chiropractic, dentistry, podiatry, or osteopathy? ____Yes ____No, List the referring provider name, address, phone

If you were not referred by a doctor to NBMT, is there a licensed doctor of medicine, chiropractic, dentistry, podiatry, or osteopathy who you would like for NBMT to inform of your visit here? ___Yes___No. List the name/address/phone of the provider to inform.

PATIENT'S CONSENT TO CONSULTATION WITH MEDICAL PROVIDER

SPECIAL NOTICE: IF you DO NOT have a licensed doctor of medicine, chiropractic, dentistry, podiatry, or osteopathy, NBMT will make a suggestion from a list of available providers. You are not required to agree with the suggestion or select from the list. You are not required to have a doctor or agree for your doctor to be informed of your receiving services at NBMT. However, when your doctor has not been notified of services you are receiving at NBMT then the services cannot continue beyond 30 days (with physical therapist).

PLEASE INITIAL APPROPRIATE LINE CHOOSE ONLY ONE

_________*I CONSENT* to NBMT notifying and consulting with the licensed doctor of medicine, chiropractic, dentistry, podiatry, or osteopathy identified above concerning my treatment at NBMT.

_________*I DO NOT CONSENT* to NBMT informing the licensed doctor of medicine, chiropractic, dentistry, podiatry, or osteopathy, of my initiation of treatment at NBMT.

________ *I DO NOT HAVE* a licensed doctor of medicine, chiropractic, dentistry, podiatry, or osteopathy. I acknowledge that NBMT presented a list of available providers and suggested a provider. I UNDERSTAND MY TREATMENT CANNOT CONTINUE BEYOND 30 DAYS WITH PHYSICAL THERAPIST.

BY SIGNING BELOW I PROMISE AS FOLLOWS: I have read and filled out this payment notice and treatment consent of my own free will. I understand that I can ask NBMT staff questions concerning this document. If I had any questions, I have asked and they were answered to my satisfaction. I understand that NBMT will not bill my insurance company, Medicare, or Medicaid. I understand that I may be able to go to a different provider and receive the same services covered in whole or in part by my insurance, Medicare, or Medicaid. I choose to receive my services from NBMT and pay for them myself. I understand I must pay for services in full when they are rendered.

PRINT CLIENT NAME____

CLIENT SIGNATURE_______________________________________DATE_____________

OR

LEGAL REPRESENTATIVE____

LEGAL REP SIGNATURE____________________________________DATE_______________

RELATIONSHIP TO CLIENT____

How did you hear about me?

___Referral by friend or Dr. Name: ____

___MFR online directory ____Website / Internet search _____Facebook / Instagram
___Synergy Yoga ____Herald citizen Ad ____Bathroom ad ____Radio
___Other____

Describe the primary complaints that bring you here today.

When and how did your symptom(s) begin? Date: ________

List the activities that you are having difficulty with or are unable to do currently due to this condition. (work, housework, yardwork, athletic activities, walking etc).

SYMPTOMS CURRENTLY EXPERIENCING:

PAIN: On a Scale from 0-10 (0=painfree, 10=worst imaginable pain),

how would you rate your pain?

Location of Pain:_______________________________Presently(0-10)_____ Best_____ Worst____

Other location:_________________________________Presently(0-10)_____Best______Worst____

Numbness or Tingling? ____Yes ____No Location _______________________________________

Headache / Dizziness? ____Yes ____No How often / describe?_____________________________

Sleep disturbance? Anxiety / stress / depression symptoms?

What makes the symptoms better?

____

What makes the symptoms worse?

Have you ever received any treatment? Describe previous treatments

Goals for therapy: Such as activity you cannot do that you want to be able to do?

____

Please indicate all past medical history as it may be relevant to your treatment (even as a child).

SURGERIES: (list all procedures for which you have received anesthesia even minor ones)

1. Date:____________Type:____

2. Date:____________Type:____

3. Date:____________Type:____

Have you had any car accidents, falls, or other severe accidents?

____

ALLIERGIES: Do you take allergy shots? YES NO List______________________________

Are you allergic to any medicines or medical dyes? : YES NO List:____________________

____

Latex? YES NO Foods? YES NO Chemicals? YES NO List:______________________

HAVE YOU BEEN IN THE HOSPITAL? What for and when?

____

MEDICATIONS CURRENTLY TAKEN: (Include supplements, over the counter pain medicines, herbal and homeopathic remedies).

____

What are you taking for pain? How often? ____

Is there a chance you may be pregnant at this time? Yes ___ No___

MEDICAL CONDITIONS YOU CURRENTLY HAVE:

____Thyroid ____Blood pressure ____Heart problem ____Arthritis ____Diabetes ____

LIST:____

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (NO or list details if applicable)

HEART ATTACK / CONGESTIVE HEART FAILURE / HEART CATH / HEART SURGERY (Describe & Dates) ____

SEIZURES, STROKE, TIA, HEAD INJURY, Concussion, Dizziness___________________

CHIARI MALFORMATION, VERTEBRAL ARTERY SYNDROME, SEVERE WHIPLASH or LIGAMENT INSTABILITY IN NECK (Date)____

BLOOD CLOTS or TAKE ANTICOAGULANT MEDICATION SUCH AS COUMADIN / PLAVIX / ASPIRIN?____

PACEMAKER, HEART ARRHYTHMIA/ CIRCULATION PROBLEMS___________________

LUNG / EMPHYSEMA / COPD / SEVERE ALLERGY / ASTHMA? YES NO

DIABETES: YES NO

DISEASES OF KIDNEY, LIVER, STOMACH, GALL BLADDER, PANCREAS, CANCER, LEUKEMIA? (Describe)

____

BROKEN BONES / ORTHOPEDIC INJURIES /ARTHRITIS / FIBROMYALGIA (describe)

OSTEOPOROSIS : YES_____No_____

SYSTEMIC DISEASE / AUTOIMMUNE DISEASES SUCH AS MS, RA, ALS, Lupus?

ANXIETY, DEPRESSION, ADD/ADHD, ASPERGER'S, AUTISM, PTSD, BIPOLAR DISORDER, SCHIZOAFFECTIVE DISORDER, Etc?___________________________

Have you ever been or recently been attacked, hit, kicked, slapped, punched, abused sexually? (emotional trauma may be relevant to your therapy) ____YES ____NO

DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS (Check if applicable)

___Sprains/Strains ___ Muscle tear/ sore muscles ___ Tendonitis/bursitis ___Stiff achy joints

___Swollen joints or limbs ___ Weakness or Fatigue ___ Trembling/twitching muscles

___ Menstrual/ Pelvic area pain ___ Breast tenderness / numbness /lump

___Sweaty palms ___ Cold hands/feet ___Night sweats ___Hot Flashes

___Blushing/flushed face ___Heart palpitations / arrhythmias___ Heartburn/indigestion
___abdominal pain ___ Frequent urination or difficulty urinating ___Dark colored urine
____Painful urination ___ Urinary leakage___ Bowel leakage ___ constipation

___Diarrhea ___Pale or light colored stools ___Black, tarry stools

___ Skin rashes or open wounds ____Itching or burning of skin

___Grinding of teeth (TMJ) or popping of jaw___ Mouth sores ___Problems with teeth

___ Weight Change >15 lbs ___ Tension headaches or migraines___ Sinusitis

___ Depression/Anxiety ____Visual Disturbances or vision changes ____Feeling faint or dizzy

INFORMED CONSENT TO USE OF OILS / PHYSICAL THERAPY MANUAL THERAPIES

ESSENTIAL OILS: Do you have any chemical sensitivities to scents or oils or lotions? I use therapeutic grade essential oils in therapy sometimes and if you do not wish me to use those or have specific problems please let me know.

I want you to use essential oils during therapy. ___YES ____No INITIALS_________

Myofascial release is a hands on technique which is most effective with direct contact with skin. You may wear shorts, sports bra, or bathing suit and /or underwear. Direct contact with areas on or around the breasts, hips, sacrum, or coccyx area externally are sometimes needed for progress, if you have any discomfort with therapist applying hands on techniques in any areas, please discuss with your therapist.

By signing below you agree to hands on therapy in any areas required to properly treat you. You may choose during any session to tell therapist if you are uncomfortable with any techniques and we can modify or find other techniques or perform work over clothing, which may not be as effective. Please notify therapist of any concerns you have regarding treatment. You may also bring a family member into the session with you if you would like for support / comfort.

MFR also can elicit emotional healing responses. Please know that you are encouraged to seek a professional counselor for any emotional or mental problems. We are here to support your healing but we are not licensed professional counselors.

MFR can also elicit "healing crisis" which may cause temporary soreness, increase of pain, spasms, twitching/jerking of muscles, detoxing symptoms such as nausea, diarrhea, vaginal spotting, headache, or dizziness. This effect is usually temporary 24-48 hours and is part of the process of healing. Please contact your doctor or emergency room if you have any symptoms that are severe or concerning.

INTRA-ORAL CONSENT: Techniques may be performed inside the mouth for neck/head/jaw pain by PT. These techniques may sometimes elicit "healing crisis" such as headache or dizziness, or jaw or neck pain.

_____YES ____ NO INITIALS_______ I agree to intra-oral techniques as indicated

BREAST / SACRAL / PELVIS AREA CONSENT: EXTERNAL Techniques may be performed in these areas by PT. This consents only to the external treatment.

I agree to techniques externally as indicated in the breast / sacral / pelvis areas:

_____YES____NO INITIALS_______

I CONSENT TO HANDS ON TREATMENT FULL BODY AS DESCRIBED

By signing below you are consenting to evaluation and further treatments, verifying the information you have given above is correct to the best of your knowledge, and understand the policies as stated above, and agree to these terms.

Signature:_______________________________________ Date:_________________

PRIVACY PRACTICES NOTICE

"I understand that New Beginnings Myofascial Therapy LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment."

I authorize New Beginnings Myofascial Therapy LLC, and/or Sheri Brimm PT and/or Optimal Health and Performance staff to consult and share documentation of my treatment with physicians, medical or health providers, or insurance companies involved in my care. Further release of medical records will not be performed unless authorized by me. NBMT / OHP may also utilize my cell phone number, home phone number, email address, or postal address to send me notifications of appointments and notify me of services or information that may be helpful or relevant to me. NBMT / OHP will not share information with other entities unless authorized by me.

SIGNATURE____DATE________________