Name: _____ DOB: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ *Email:_____

*Topline Therapy will not share or sell your email. We use emails to send out periodic newsletters, please write your email to consent to this.

Primary Dr: _____

Reason for visit: _____

Informed Consent

You may experience an improvement in your symptoms and functional activities. You also may experience an increase in your current level of pain. Alternatives are usually not well tolerated. If at any time you feel that the treatment is not well tolerated or that the treatment is not progressing, we will ask you to see your doctor to continue the treatment.

Please note that we make no promises or guarantees regarding a complete resolution and/or correction of your condition. However, we will work with you to achieve optimal improvement.

I have read the above information and consent to the evaluation(s) and treatment provided by Topline Therapy Clinic

_____ ***CONSENT TO TREAT***

I request and authorize the staff of Topline Therapy Clinic to provide me with treatment, and to perform any procedures now contemplated or such additional procedures as my doctor or physical therapist may deem reasonable and necessary.

_____ ***ASSIGNMENT OF INSURANCE BENEFITS***

I authorize that the payment of my insurance benefits be made directly to Topline Therapy Clinic for all services delivered; if I am paid directly, I will promptly pay the Topline Therapy Clinic all monies paid to me.

_____ ***GUARANTEE OF PAYMENT***

I understand that ALL payments designated as "the patient's responsibility" such as co-insurance, deductibles, and co-payments are due and payable at the time of service or receipt of statement. I guarantee I will pay the amount deemed "my responsibility" by my insurer within 30 days of statement date or a $10.00 late charge will be added to each monthly statement.

Please list the medications you are taking and the dosage.

Medicine	Dosage	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ Due to cancellations and no-shows, we may assess a $50 no show/late cancellation fee if not notified at least 24 hours in advance, we are requesting a credit card for you to register with our office. We will not charge your card without first notifying you that a $50.00 fee will be charged. My insurance company cannot be billed for cancellations/no shows; therefore, I will be required to pay this fee on my next visit.

CC #_____ EXP: _____ CCV: _____

Health Insurance Portability and Accountability Act (HIPAA)

Acknowledgement of the Notice of Privacy (Located on the front desk)

I have been shown where Topline Therapy's Notice of Privacy Practice is located. I acknowledge that outside of the purpose of treatment, payment, certain health care operations, or as otherwise permitted or required by law, I must give Topline Therapy my written authorization to disclose any of my protected health information.

I certify that the information I have provided Topline Therapy Clinic for payment including, but not limited to, related accidents, illnesses, or other insurers is accurate and truthful.

Print name: _____ Date: _____

Signature: _____ Date: _____

Patient Guardian (if under 18) _____ Date: _____

Emergency Contact

In case of an emergency, please provide TWO (2) emergency contacts and their information.

Emergency Contact #1:

Name: _____ Relationship to you: _____

Primary Phone #: _____ Alt Phone #: _____

Emergency Contact #2:

Name: _____ Relationship to you: _____

Primary Phone #: _____ Alt Phone #: _____

DRY NEEDLING PATIENT CONSENT

Any medical procedure involving the placement of a needle into the body has some inherent risk. We ONLY use sterile and disposable needles and ALWAYS dispose of each needle according to government standards. We ask that you read the following so we may help you understand everything you need to give us verbal and written consent to proceed with Dry Needling. The following is a list of conditions that are the most common, absolute, and relative contradictions to Dry Needle therapy. PLEASE INFORM US IF YOU HAVE ANY OF THE FOLLOWING:

Spontaneous bleeding or bruising

Irregular heartbeat

Tendency to bleed (taking blood thinners)

Compromised immune system

Previous adverse reaction to Dry Needling or Acupuncture

Schizophrenia

Seizure induced by previous medical procedure

Hematoma

Pregnancy

Eczema or Psoriasis

Recurrent infections

Epilepsy – stable or unstable

Chronic edema or lymphedema

Depression

Unstable diabetes	Chronic fatigue
Unstable angina	Acute cardiac arrythmias
Open skin wounds or injuries	Allergy to nickel or Chromium
Congenital or acquired heart valve disease	HIV
Recent cardiac surgery	Hepatitis B or C
Recent radiotherapy	Laminectomy
Varicose Veins	Malignancy

Please circle one: ***I DO*** or ***I DO NOT*** - have surgical/artificial implants in my body.

Please circle one: ***I DO*** or ***I DO NOT*** - have a pacemaker/defibrillator implanted in my body.

By signing below, I am making clear that I understand that there is some risk involved in any procedure that involves inserting needles of any kind into the body. These have been outlined above and I understand them. I have been given the opportunity to discuss this at length with my clinician. I wish to proceed with dry needling.

_____	_____
Patient Signature	Date
_____	_____
Clinician Signature	Date
_____	_____
Patient Guardian (if under 18)	Date