

Consent for Treatment

The goal of physical therapy treatment is to alleviate pain, restore appropriate movement patterns and to return you to your previous level of function (or better). Physical therapy involves hands-on manual therapy (including soft tissue and joint mobilization and spinal manipulation), modalities (such as hot/cold packs, ultrasound, electrical stimulation, dry needling), therapeutic exercise and a home exercise program. All treatments are determined after a thorough evaluation by a licensed physical therapist and updated with periodic re-evaluations.

Common side-effects may include, but are not limited to, muscle soreness, swelling, and burns. Because much of the treatment is based upon movement to restore joint range of motion and muscle strength in appropriate patterns, initial muscle soreness is common 24-48 hours after treatment. This soreness should not interfere with your daily activities.

Integrative Dry Needling involves placing a small needle into the tissue that is tender with the intent to normalize the physiology of the area and regain homeostasis

The most serious risk associated with Dry Needling is accidental puncture of a lung (pneumothorax). The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from Dry Needling is unlikely.

I have reviewed the Notice of Privacy Practices regarding the use of and disclosure of my health information.

I have had the opportunity to ask questions and consent for treatment at Charlestown Physical Therapy and Health Services LLC.

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Signature (Parent or Guardian's Signature if under 18)

Date

Financial Responsibility

I authorize Charlestown Physical Therapy and Health Services LLC to send claims and any necessary information for payment to my insurance carrier or other third party payor on my behalf. I authorize my third party payor to pay benefits directly to Charlestown Physical Therapy and Health Services LLC.

It is your responsibility to be aware of your current insurance coverage, deductible, co-pay/co-insurance. Every effort will be made to assist you in working with your insurance company. Co-pay/Co-insurance payment is expected at the time of visit. A payment schedule can be set-up if needed in cases of high co-pay/co-insurance or deductible amount. The patient will be responsible for any services not covered by insurance. There will be a \$20 fee for any returned check.

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Signature (Parent or Guardian's Signature if under 18)

Date

Attendance Policy

Please call at least 12 hours before your scheduled appointment if you need to reschedule. There will be a \$20 charge for any missed appointments that you do not call to cancel. This charge is billed to the patient, not the insurance carrier. Charlestown Physical Therapy and Health Services LLC reserves the right to discontinue treatment if you have missed 2 appointments without calling.

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Signature (Parent or Guardian's Signature if under 18)

Date