Steve Kravitz Physical Therapy
Dr. Steve Kravitz PT, DPT, CST
2000 Glen Echo Road, Suite # 209 Nashville, TN 37215
Phone: 615-840-3281 / Fax: 646-537-1748
E-mail: admin@stevekravitz.com / Website: www.stevekravitz.com

(Please print. All information will be confidential)

Name: _____ Today's Date: _____
First Last

Birthdate: _____ Sex: M / F Age: _____ SS #: _____

Employer: _____ Occupation: _____

Referring Physician Name: _____ Phone # of Referring Physician: _____

Home Address: _____

E-mail Address:_____ Referred By:_____

Home #:_____ Cell #: _____

Insurance Co.: _____Insurance ID #:_____ Insurance Phone # _____

Emergency Contact: Name _____ Phone: _____ Relation: _____

1. What is the main reason for your visit today ? _____

2. Have you had any surgeries or hospitalizations in the past? (Y / N) If so, please describe and provide the year that the incident occurred:

_____

3. Please list any past or existing physical injuries or chronic illnesses/diseases. Please describe briefly:

_____

_____

4. What is your main goal for ongoing treatment? _____

_____

Financial Acknowledgement & ABN (Advance Beneficiary Notice of Non Coverage)

I understand that I am financially responsible for all charges on the day of each treatment whether or not these charges are covered under insurance. I hereby authorize the release of all information to secure payment. A minimum of 24 hours notice of cancellation is required and this office will be notified by 12:00 (noon) the day before any scheduled treatments if cancellation is necessary. Patient is responsible for payment for any missed or late cancellation of appointment (s) as described above. If payment is not made for any treatment or missed appointments, I authorize the use of my credit card on file for processing payment.

Furthermore, your signature below will acknowledge and consent that I will not be reimbursed through Medicare and this serves as an Advance Beneficiary Notice of Non Coverage (ABN). I agree that my physical therapy goals have been met and that the services I will receive at this practice will be considered a wellness visit. I also agree that these expenses will be considered out of pocket expenses and I will not be able to submit a receipt to Medicare for the visits at this office for reimbursement.

Signature: Patient / Guardian : _____ Date: _____

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HIPAA – PRIVACY ACT INFORMATION

The privacy of all medical records and other individually identifiable health information must be protected at all times. Information relating to a patient's health care history, diagnosis, condition, treatment, or evaluation shall be considered individually identifiable health information. Confidentiality of this health information must be maintained at all times, and may only be disclosed with the express written consent of the patient. Non-individually identifiable health information, (e.g. health information that cannot be linked to a specific patient) is not included within the definition of protected health information.

Patient information can be used or disclosed only for purposes of health care treatment, payment, and operations. Health information cannot be used for purposes not related to health care without explicit authorization from the patient.

The provider shall not publish or otherwise make generally available any information or data that identifies a patient for purposes other than treatment, payment or other health care operations, without his or her express written consent.

All individually identifiable health information shall be maintained by the provider in a confidential manner that prevents unauthorized or inadvertent disclosure to third parties.

I have read this form and understand my rights to privacy as a patient.

Patient/Guardian Name (SIGNATURE)_____

Date: _____

Consent to Physical Therapy Services Without A Referral

In order for Steve Kravitz Physical Therapy to provide a patient with physical therapy services without a written or oral referral from a doctor of medicine, chiropractic, dentistry, podiatry, or doctor of osteopathic medicine, the patient must provide informed consent. To acknowledge your informed consent and to receive "direct access services," please sign below.

I, _____, (print name) choose direct access to physical therapy services and forgo the right to have a licensed doctor of medicine, chiropractic, dentistry, podiatry, or doctor of osteopathic medicine informed of the initiation of physical therapy treatment and ongoing treatments thereafter.

Patient/Guardian Name (SIGNATURE): _____

Date: _____

STEVE KRAVITZ PHYSICAL THERAPY

Informed Consent to Physical Therapy Treatment and Care

I hereby request and consent to the performance of physical therapy treatment and other treatments provided as this practice including: craniosacral therapy, visceral manipulation, myofascial release, nerve mobilization, orthopedic manual therapy, dry needling, cupping, and/or whole food nutrient and diet recommendations ("treatments") on me (or on the patient name listed below for whom I am legally responsible) by a physical therapist and/or practitioner employed by Steve Kravitz Physical Therapy ("provider").

I have had an opportunity to discuss with the doctor or clinic personnel the nature and purpose of treatment provided at this clinic. I understand and am informed that, as in the practice of medicine, in the practice of physical therapy treatment and treatments stated above, there are risks to treatment including, but not limited to, fractures, disc injuries, dislocations, sprains. It is not reasonable to expect the provider to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the provider to exercise judgment during the course of the procedure which the provider feels at the time, based upon the facts then known, is in my best interests.

Physical therapy treatment and all treatment performed at this clinic involves science, philosophy, and art of locating and correcting misalignments and dysfunction in the body, and as such, is oriented toward improvement of function relative to range of motion, muscular and boney alignment, and neurological aspects. There has been no promise, implied, or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. It is my intention to rely on the provider to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.

The following therapies require precautions and contraindications explained, to perform specific services prior to the treatment.

Dry needling involves inserting a tiny monofilament needle in a muscle(s) in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. Dry needling is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they must be considered prior to giving consent for treatment.

Though unlikely there are risks associated with this treatment. The most serious risk with dry needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest xray and no further treatment. The symptoms are shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern. On occasion, the provider will attach e-stim to the dry needles, which stimulates the tissue more deeply. It is your responsibility to make the provider aware of any of the precautions listed below or any health conditions which you feel may be adversely effected by dry needling or dry needling with e-stimulation.

Precautions:

- Hemophilia or other bleeding/clotting disorders
- Patients taking blood thinners
- An aversion to needles
- Local or systemic infections
- Post-surgical sites
- 1st trimester pregnancy
- Vascular diseases/varicose veins
- Pacemaker
- Diabetics
- Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving dry needling and/or dry needling with e-stimulation

I further understand that the above-listed conditions are contraindicated for dry needling and/or dry needling with e-stimulation and I have informed my therapist/physician of any and all medical conditions, even those not listed as contraindications.

Cupping therapy will leave bruise-like marks that will last several days to several weeks depending on the severity of my condition. While most marks fade and disappear after a few days, there are times when marks could take up to 15 days to clear and in rare cases, it has been reported that marks have taken up to 21 days to fully clear. These areas of bruising or discoloration are typically not painful, but can on occasion have soreness, itching and there may be soreness in the surrounding muscles. Cupping therapy is a medical treatment, not a novelty and should be treated accordingly. Your acupuncture physician will determine which areas are

most appropriate for cupping, which type of cupping methods should be used and where how many cups should be applied, the length of time the cups should remain on and which cupping techniques (stationary, moving, etc.) to employ. This is not a service in which the patient should expect to dictate the terms of the service such as in a massage service.

Contraindications:

- Hemophilia or other bleeding/clotting disorders
- Patients taking blood thinners
- Weak patients or those who have been ill.
- Abdomen on pregnant women
- Diabetics. Especially those with uncontrolled blood sugar as they may not be able to feel pain properly.
- Those who are unable to experience heat or pain properly
- Those who have circulatory conditions
- Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.

I further understand that the above-listed conditions are contraindicated for cupping therapy and I have informed my therapist/physician of any and all medical conditions, even those not listed as contraindications.

Whole Food Nutrient and Diet Recommendations

Providers at Steve Kravitz Physical Therapy may make recommendations for Whole Food Nutrients and Diet. Product dosages are sometimes different than the doses that appear on the product labels. Please refer to the product labels for standard dosage recommendations. It is at my sole discretion to follow the recommendations made by providers at Steve Kravitz Physical Therapy and hold the providers harmless for any negative health consequence that may arise in connection with these recommendations. It is my responsibility as the patient to notify my provider of any pre-existing or new diagnoses, health conditions, and/or medicines that I'm taking or have taken in the past. In addition, it is my responsibility as the patient to notify my provider immediately of any negative consequence(s) or side effect(s) and to stop the whole food nutrient and/or diet recommendation until further evaluation is done and you consult your primary care physician.

The following claims regarding foods and nutrients have not been evaluated by the FDA. The following information is not a substitute for medical care or counseling and is not intended for the diagnosis, treatment or prevention of disease or symptoms.

Supplements containing whole food ingredients are not a substitute for eating whole foods.

With my signature, I hereby consent to the performance of this procedure(s). I have read, or have had read to me, the Informed Consent to Physical Therapy Treatment and Care. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions (s) for which I seek treatment. By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Printed Name: _____

Signature of Patient/Relative or Guardian: _____

Relationship to Patient, if signed by person other than Patient: _____

Date: _____

STEVE KRAVITZ
PHYSICAL THERAPY

CRANIOSACRAL THERAPY
VISCERAL MOBILIZATION
LYMPHATIC DRAINAGE
MYOFASCIAL RELEASE

Credit Card Authorization Form

Name (as it appears on the credit card) _____

Credit Card Type _____ MasterCard _____ Visa _____ American Express

Credit Card Number _____

CVV Code _____ (3 digit code on back of the card)

Expiration Date _____

Billing Address _____

_____

_____

Financial Acknowledgement

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Signature Patient/Guardian : _____ Date: _____

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