## CONSENT FOR TREATMENT

For and in consideration of the medical treatment, which I may receive while a patient of **Acadian Comprehensive Therapy Services, Inc.**, herein after referred to as **ACTS**, I either separately or collectively consent to treatment, voluntarily and knowingly, by me if of age and competent of for me, if a minor or incompetent, by my parents, guardian or nearest relative, as the case may be, to the said member of **ACTS** separately or collectively, to carry out, or cause to be carried out such medical treatment, as prescribed or ordered by my physician.

## AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT BENEFITS

I hereby authorize **ACTS**, or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable for related services. I request that authorized Medicare or Insurance payments of medical benefits be made to **ACTS**, or to any consulting physician or entity used in connection with this service (to be used only if necessary to file claims).

## GUARANTOR RESPONSIBILITY

In consideration of the services, I agree that I am solitarily liable to **ACTS**, for and hereby guarantee the payment of all facility charges incurred for my treatment in accordance with the orders of my prescribing or consulting physician(s), including any facility charge not paid, for any reason, by any payer or insurance company. I further agree that payment is due in full within 45 days of my discharge and that an interest rate of 11% per annum may be assessed against the balance remaining after payment is due as well as attorney fees of 25% of the principal and interest due if the account is referred to an attorney for collection. If a balance cannot be paid in full after 45 days of my discharge, I agree to a payment schedule of $40 per month if my balance is $1 to $499, of $70 per month if my balance is $500 to $999, of $100 per month if my balance is greater than $1,000.

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by **ACTS**, and if this assignment is rejected, modified, or not paid within a reasonable time after if has been filed, it will by my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.

This authorization and assignment may be revoked by me at any time by a written notice; I agree that a photocopy of this form may be used in lieu of the original.

**Intramuscular Manual Therapy aka Trigger Point Dry Needling (TDN) Consent Form**

IMT / TDN involves placing a small needle into the muscle at the trigger point which is typically in an area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms.

IMT / TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint paint, as well as to increase muscle performance. Like any treatment there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

**Risks of the procedure:**

Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and 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. If you feel any related symptoms, immediately contact your IMT / TDN provider. If a pneumo is suspected you should seek medical attention from your physician or if necessary go to the emergency room.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. 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 IMT / TDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily Fluids? **Yes** **NO**

**If you marked yes, please discuss with your practitioner.**

________________________________________

Please print your name

________________________________________ ____________________________

Signature Date