THE MOVEMENT SCIENCE CENTER, LLC

INITIALS

Patient Name: ____ SSN: _____________________

Please read the following statements and **INITIAL** in the space provided.

- ______ Some services may be denied by your insurance company due to plan, medical necessity, or other policy limitations.
- ______ You are responsible for the cost of all services and supplies not fully covered or denied by your insurance. Copays or estimate of patient responsibility due at the time of visit.
- ______The cost of DME (durable medical equipment) is the responsibility of the patient; billing codes will be provided if you wish to file with your insurance for DME.
- ______You are required to inform us of any home healthcare or hospice care or you will be responsible for uncovered charges.

ASSIGNMENT OF BENEFITS

My signature below acknowledges that I accept liability for payment of all charges incurred during the course of my treatment that are either denied or not paid by insurance

- I authorize the release of all medical and/or other information necessary to process all claims pertinent to my medical care for services rendered by The Movement Science Center, LLC.
- I authorize payment of medical benefits to The Movement Science Center, LLC for services rendered and understand that their participation with my insurance plan does not guarantee payment of my bill.
- I agree to promptly pay any balance remaining after my claim has been processed. This can include, but is not limited to, charges that were denied or applied to my coinsurance, deductible, out of pocket expense, plan exclusions, or non-covered supplies and services. I authorize my credit card on file to be charged for the balance.

I HAVE READ AND UNDERSTAND MY OBLIGATIONS:

____ __________________________

Patient or Guardian Signature Date

FINANCIAL POLICY

Please be thorough when providing us with your insurance information. Claims cannot be submitted without a copy of your insurance card.

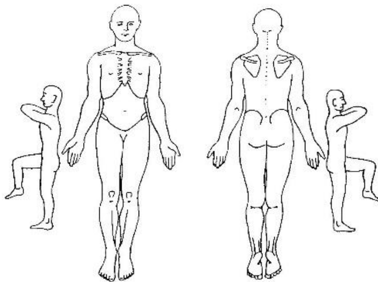
- Some plans require an authorization to be issued prior to services being rendered. If only a few visits are authorized, renewal of the authorization will be necessary for further treatment. We will attempt to obtain the initial authorization for your visit. However, we ask your cooperation in tracking the number of visits used and informing the front desk when your authorization needs to be renewed.
- If your claim has not been paid within 30 days, we ask that you contact your insurance carrier to help expedite the process.
- Once your claim has been processed and either paid or denied, you will be responsible for payment in full. If you do not agree with the denial, it is your responsibility to pay for services and then take it up with your insurance carrier.
- SELF PAY PATIENTS: This category includes those people with no insurance and the patients who have an indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the services are rendered. If you will not be able to pay for our services in full, we will work with you by setting up a regular payment schedule. This must be done before treatment is rendered.
- MEDICARE PATIENTS: We will bill Medicare as well as secondary insurance, but if payment is not received from your secondary insurance within 45 days, you will be notified and must pay our office the balance due. You must then contact your secondary insurance to pay you for the balance you paid our office.

If you have any questions regarding this policy, please ask prior to being seen by the therapist.

____ __________________________

Patient or Guardian Signature Date

Name____Date________________
Address____City_____________________Zip_____________
Phone Number________________________Email____
Date of Birth______________ Height_____________ Weight______________ Blood Pressure____________
Allergies:____
Occupation, Job Tasks____
Injury onset date:____________ Surgery performed: Yes/NO Surgery date:_______________________
Pain location (please specify right or left if applicable) :____
History of present condition/mechanism of injury: ____
____
Do you believe that physical activities might make your pain worse? YES NO
Patient goals:____
Have you received treatment for this problem? If so, explain____________________________________
Please list any test performed for this problem (x-ray, labs, ext…)_________________________________
For Women: Are you pregnant or think that you may be pregnant? (Circle one) YES NO



Please mark the areas where you feel symptoms on the chart to the left with the following symbols to describe your symptoms:

↓ Shooting/sharp pain
° Dull/aching pain
III Numbness
= Tingling

Using the 0 to 10 pain scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

A. The worst pain you've had: 0 1 2 3 4 5 6 7 8 9 10

B. The current level of pain you're having- 0 1 2 3 4 5 6 7 8 9 10

C. The level of pain you've had at best- 0 1 2 3 4 5 6 7 8 9 10

When are your symptoms the worst? Morning Afternoon Evening Night During Exercise After Exercise

When are your symptoms the best? Morning Afternoon Evening Night During Exercise After Exercise

Circle the following aggravating factors:
Sitting standing walking going up stairs going down stairs
sitting to standing bending voiding lying down coughing/sneezing

Previous History of Similar Symptoms: YES NO **General health:** GOOD FAIR POOR

Home Health Care: YES NO **Unexplained weight loss:** YES NO

History of falls (2 or more falls with 1 resulting in an injury within the past year): YES NO

MEDICAL HISTORY:

o No known significant Past Medical History	o History of Cancer
o Alzheimer's	o Huntington's
o Cardiovascular Disease	o Immunosuppression
o Cauda Equina Syndrome	o Lupus
o Cerebral Vascular Accident	o Muscular Dystrophy
o Current Infection	o Obesity
o Diabetes Mellitus Type I	o Osteoarthritis
o Diabetes Mellitus Type II	o Parkinson's
o Fibromyalgia	o Rheumatoid Arthritis
o Fracture or Suspected Fracture	o Traumatic Brain Injury
o High Blood Pressure	o Other-

If you use tobacco, drink alcohol or caffeine, please list how often and quantity.
____

Please list any surgeries or cause of hospitalization you may have had, including dates.
____
____
____

Current Medications:************
Name:______________________________Dosage:_________________________Frequency:_________________
Name:______________________________Dosage:_________________________Frequency:_________________
Name:______________________________Dosage:_________________________Frequency:_________________

☐ Please check this box if you are not currently taking any medications.

1. Are you basically satisfied with your life? Yes / **No**
2. Have you dropped many of your activities and interests? **Yes** / No
3. Do you feel that your life is empty? **Yes** / No
4. Do you often get bored? **Yes** / No
5. Are you in good spirits most of the time? Yes / **No**
6. Are you afraid that something bad is going to happen to you? **Yes** / No
7. Do you feel happy most of the time? Yes / **No**
8. Do you often feel helpless? **Yes** / No
9. Do you prefer to stay at home, rather than going out and doing new things? **Yes** / No
10. Do you feel you have more problems with memory than most? **Yes** / No
11. Do you think it is wonderful to be alive now? Yes / **No**
12. Do you feel pretty worthless the way you are now? **Yes** / No
13. Do you feel full of energy? Yes / **No**
14. Do you feel that your situation is hopeless? **Yes** / No
15. Do you think that most people are better off than you are? **Yes** / No
16. Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **Yes** / No

H:________ W:_________BMI:_________

Patient Policy

Congratulations! You have made one of the best decisions for your health. Our physical therapists have doctorates in physical therapy along with advanced certifications in the field of Health and Wellness. Our physical therapists will supervise your program with appropriate staff and assistants.

In order to provide you the best service, we ask that you observe several policies:

1. Please be on time. We want to give you the full time you deserve.
2. Please keep your scheduled appointment. A "no show" can be an unpaid hour for the physical therapy staff. We have blocked this time especially for you. Treatment is effective for health benefits if you are consistent. You can achieve your goals, but only if you make a commitment to keep your scheduled appointments. We want you to succeed.
3. If you are unable to keep a scheduled appointment, please give The Movement Science Center at least **24 hours cancellation notice**.
4. After one **"no show"** without a 24 hour notification period, your account may be **charged $80.00**.
5. If you reschedule your morning appointment at a later time in the day more than three times, you will be charged an additional $20.00.
6. If you **cancel or no show for 3 appointments we reserve the right to cancel all future appointments**. You must call to reschedule all cancelled appointments. If you do not show up for the rescheduled appointment you will be discharged back to referring MD.

I have read the above and agree to abide by the policies

___________________________	_________________________
Patient Signature	Date
___________________________	_________________________
Patient Printed Name	PT Signature

H I P A A

Health Insurance Portability and Accountability Act (1996)

Notice of Privacy Policy (NPP) and Practices for Protected Health Information (PHI)

Effective February 1, 2004

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Please direct any questions about this notice to the Office Manager at The Movement Science Center 321 Veterans Blvd., Suite 100, Metairie, LA 70005 (504) 834-9259

PURPOSE OF THIS NOTICE

The Movement Science Center understands the importance of keeping our patients' protected health information (PHI) private. We have always been careful with confidential patient health information, however the federal HIPAA laws require healthcare providers to provide written notice of how we may use and disclose PHI records. Please be assured of our commitment to confidentiality and privacy.

Types of Personal Health Information We Collect

Each time you visit The Movement Science Center our therapists and staff make a record of your visit. Typically, your chart contains your initial evaluation, diagnosis, plan of treatment, recommended exercises, and modalities and frequency performed. This Protected Health Information (PHI) is referred to as your medical record or chart and serves as a basis for planning your care and treatment.

Your PHI may also include authorizations, correspondence, health insurance forms, billing information, as well as identifying information for both our patient and their parents or guarantors. Identifying information includes name, date of birth, sex, social security number, address, numbers for home, work, or cell phones, etc. These records may also include reports, test results, and correspondence of consultations obtained at other medical facilities.

We retain this information as required by law for a minimum of 6 years. We limit the collection of personal information only to that which is necessary to provide quality medical care and for insurance and reimbursement purposes.

How We Protect Personal Information

We protect PHI by limiting access to our patient's information to only those persons who need to know that information to effectively provide treatment, and to provide required documentation for reimbursement and insurance purposes. Each employee of The Movement Science Center must sign a Confidentiality Statement assuring that they understand their responsibilities and the importance of complying with our policies designed to protect your privacy.

Disclosure and Uses of PHI for Treatment, Payment, and Healthcare Operations

Treatment
Within the law, we may share and/or disclose any of the personal information we collect for the purpose of treatment, reimbursement documentation and healthcare operations. Our therapists may share the patient's information with personnel within The Movement Science Center involved in coordinating patient medial care and treatment. An example of this would be the type and frequency of modalities to be performed.

Our therapists may provide information to the referring physician and other healthcare providers so that they may assist us in treating our patients.

Payment
As a courtesy, we will bill our patient's HMO or PPO plan for medical services we provide. We disclose PHI in billing because the payors require diagnosis and procedure codes before they will process your claim for payment. We may disclose PHI information with affiliates such as health insurance companies with whom we are contracted, licensure and for audits.

Healthcare Operations
Because we treat patients of all ages, we may communicate health information to their parent or guardian, or the person acting in authority on behalf of a minor child. We may contact the patient, parent, or guardian at their home, office, or cell phone to relay information such as appointment reminders or referral questions. We may contact the referring physician regarding a patient's progress and plan of treatment.

We follow government regulations in instances of serious situations such as a public health risk, to prevent or lessen the risk of patient or public safety, and for disaster relief efforts.

We may disclose PHI as required by law to judicial or administration proceedings, licensure, or disciplinary actions in response to a subpoena, discovery request or other lawful process. We may disclose PHI for peer review and operations assessment

We do not disclose information to any third party without the written permission of the patient, parent, or guardian. We may disclose authorized written information via copy, fax, or mail.

Individual Rights to your Personal Health Information

We have procedures for our patients, their parents, or guardians to access or inspect the PHI we collect. We will make this information available to you upon written request, by appointment only, and under employee supervision. You have the right to request amendment or correction to the patient's health record by delivering a written request to our office. Our therapists are not required to make such amendments. If an amendment is denied, you may file a statement of disagreement and request that the request for amendment and any denial be attached in all future disclosures of your PHI.

Privacy Policy Amendment

We reserve the right to amend our privacy policy from time to time. Any revisions will be available to you upon your next office visit.

Posting our Privacy Notice

Our privacy notice is handed individually to each patient for signature. Additional copies are available for parents not present in the office who should review, sign, and acknowledge receipt by return mail.

Filing a Complaint

If you have any questions, need further information, or want to file a written complaint regarding the handling of your PHI, please call The Movement Science Center at (504)834-9259 or write 321 Veterans Blvd. Suite 100, Metairie, LA 70005.

If you feel the patient's rights have been violated, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the Federal Government.

My signature below acknowledges that I have been informed of The Movement Science Center's privacy policy concerning protected health information.

____   ____________________
Signature of Patient, Parent, or Guardian   Date

____
Printed Name

INTRAMUSCULAR MANUAL THERAPY AKA TRIGGER POINT DRY NEEDLING (TDN) CONSENT FORM

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. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.

TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, 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 associate with this treatment. The most serious risk associated with TDN is accident 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 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 our 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 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.

____
Print your name.

_______________________________________ __________________________
Signature Date

______ I was offered a copy of this consent and refused.