BioDynamic Manual Therapy, LLC

PATIENT QUESTIONNAIRE

Evaluation Date: _____

Patient Name: _____ DOB: _____ Age: _____

Address: _____

_____

Home/Cell Phone: _____ Work Phone: _____

Email: _____

Emergency Contact (Name, Number, Relationship): _____

Primary Physician/Contact Number: _____

Other Professionals Involved in your Care: _____

Primary Concern/Reason for Seeking Care Today: _____

_____

Regarding the above listed primary concern, what positions/actions in your daily routine seem to make your symptoms

WORSE? _____

BETTER? _____

What are you limited from doing due to this current concern, if anything? _____

_____

Do you alter *how* you complete an activity in order to avoid symptoms? If so, how? _____

_____

Describe your pain (sharp, shooting, piercing, dull, etc). Constant/intermittent? What is the intensity (0 – 10)? _____

_____

List any diagnostic tests performed (i.e. x-ray, MRI, CT Scan). If you have a copy of the ***result report***, this is helpful to bring to the first session. _____

_____

List and describe all previous injuries to include major falls, bone fractures, past history of car accidents, muscle sprains/strains and any other pertinent medical information. _____

_____

_____

_____

_____

Do you have surgical or traumatic scars? (Please include year). _____

_____

_____

Do you sleep well? _____ If no, do you wake from sleep due to your symptoms? _____

What position do you typically sleep? _____

Tell me about your dietary intake and gastric function. _____

_____

_____

Do you exercise? If so, describe. _____

_____

Please list ALL medical conditions **and** health concerns. _____

_____

_____

Please list ALL current medications. _____

_____

_____

Please list all allergies. _____

Do you have or have you had any of these symptoms in the past year? (Check all that apply).

_____Unexplained weight gain or loss
_____Vertigo _____Dizziness _____Headaches _____Visual Changes
_____Numbness, Pain or Weakness? Where?_____
_____Persistent joint pain
_____Change in bowel movements? Or, other gastrointestinal issues? _____
_____Shortness of Breath _____Tired/Fatigued _____Difficulty Sleeping _____Fainting Spells
_____Persistent Nose Bleeds _____Other _____

Dental History (Please check all that apply and elaborate as needed).

_____History of TMJ Disorder _____Grind or Clench your teeth? _____Ever wear dental splint?
_____Currently using a night guard? _____Popping, clicking, or grinding in jaw? _____Jaw ever lock up?

For WOMEN ONLY – List any pertinent information about pregnancies, complications with delivery or menstrual problems

_____

_____

Have you had any other treatments for your current condition? (i.e. PT, Naturopath, Chiropractic, Massage, Acupuncture)

_____

_____

What are your goals in pursing manual therapy? _____

_____

_____

Is there anything else you feel your practitioner should know? Please state. _____

_____

How did you hear about us? _____

Thank you for taking the time to thoughtfully and thoroughly complete this form!

BioDynamic Manual Therapy, LLC

KIMBERLY M. PRUCHA, MPT

CONSENT TO TREATMENT

BioDynamic Manual Therapy, LLC is a hands-on physical therapy provider. I am a licensed physical therapist in the State of Nevada. My unique and highly specialized treatment consists primarily of manual therapy techniques and treatment forms that are not usually performed in conventional therapy settings. My goal is to provide professional, skilled, holistic manual physical therapy from a whole-person prospective in order to facilitate your return to activity. Whether providing progressive regular care to facilitate health following an injury, implementing a treatment plan to address your chronic pain, or providing maintenance care for you to maintain your chosen activities, your care will always be thorough.

Initial evaluations include a detailed verbal history, a functional and hands-on assessment to determine where the movement limitations are that are contributing to your symptoms, and an analysis/treatment. Follow-up sessions consist of a brief discussion of your response to the prior session as well as progressive treatment.

Each treatment approach will vary client to client because I tailor sessions to your specific needs and stated goals based on your history and results from evaluation. Therapy will be provided using skilled manual therapy techniques designed to improve the mobility of your body. Sessions may also include education for proper body mechanics/ergonomics during activity, and appropriate stretching/strengthening exercises to be completed and implemented at home in your daily routine.

Therapy is a teamwork effort and, therefore, each patient is encouraged to actively participate in their treatment progression. As a PT, I facilitate the progression via skilled manual input within the treatment session; your part is to make all reasonable efforts to comply with recommended home exercises.

Please note some of the hands-on treatment techniques require deep pressure which may cause periods of increased soreness and/or fatigue which may last up to 48 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern; however, please ask if you have any concerns or questions.

The number of treatments needed and recovery time can vary widely due to the age of injury, number of times injured, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at BioDynamic Manual Therapy, LLC and I authorize Kimberly M. Prucha, MPT to use treatment techniques as deemed necessary for my safe and effective treatment.

_____

Patient/Guardian Name (Please Print)

_____ _____

Patient/Guardian Signature Date

BioDynamic Manual Therapy, LLC

CONSENT FOR EMAIL/ELECTRONIC COMMUNICATION

Patients/Clients frequently request that we communicate with them by email. *BioDynamic Manual Therapy, LLC* respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email can be inherently insecure as a method of communication, we will only communicate with you by email with your written consent at the email address you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email you are consenting to email communications that may not be encrypted. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through email. *BioDynamic Manual Therapy, LLC* will not be responsible for any privacy or security breaches that may occur through email communications that you have consented to.

You may choose to limit the type of email communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please check one box below to indicate the type of correspondence you consent to receive by email:

- ☐ I do not consent to any email communication.
- ☐ I consent to receiving email communication about the scheduling of appointments or other communications that do not reveal my protected health information only.
- ☐ I consent to all communication by email, including but not limited to communication about my medical condition and advice from my health care providers.

E-mail address you are consenting to communicate through:

_____

_____ _____

Patient Signature Date

_____ _____

Authorized Representative/Guardian Signature Date

BioDynamic Manual Therapy, LLC

GENERAL POLICIES & PAYMENT AGREEMENT

Thank you for choosing *BioDynamic Manual Therapy, LLC* as your manual physical therapy provider. Before we begin services, please sign below indicating you have read, understand, and agree to the following payment policies.

GENERAL INFORMATION & POLICIES

- Evaluations are 90 minutes and all follow up sessions are 75 - 90 minutes. Please be on time for your session as I make every effort to be on time for your sessions as your dedicated therapist.
  - Initial Evaluation: $280.00
  - Follow-up Session: $220.00

- If you have questions or concerns, please make all efforts to present them at the beginning of your session so we have ample time to discuss them.

CANCELATION POLICY

- If you need to cancel, please do so as soon as you become aware of the need to do so – preferably at least 24-hours ahead of your appointment time so I may kindly extend your appointment time to other patients. Cancellations should be made by phone or text to 850-797-0636.
  - ***No-show or no call to cancel will be charged a full session rate*** Please Initial_____

- I reserve the right to cancel your appointment if you are 15 minutes late to your appointment so another patient may have your time. Please make every effort possible to call me if you know you are running late to your scheduled appointment time.

PAYMENT AGREEMENT

- **Financial Responsibility.** You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
  - ***Forms of Payment*.** Payment is due at the time of your session and payable by check or credit card. Please make checks payable to "BioDynamic Manual Therapy, LLC".

- **Out-of-Network Policy.** (*Does not apply to Medicare*) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. We are not responsible if your insurance carrier denies the claim.

- **Medicare Policy.** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since our services are not designed to meet Medicare's covered benefit requirements and we are not Medicare enrolled providers, our services will not be covered (paid) in full or in part, by Medicare (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider. We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. ***By choosing to receive our services after being fully informed of these facts, you are agreeing to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled***

provider. You also understand that since we are not enrolled Medicare providers and our services do not meet the technical requirements for Medicare covered benefits, our services are ***not*** subject to Medicare's maximum allowable charge. ***You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare or your Medicare Advantage Plan for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.***

- Medicare as a Secondary Payer. If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.

- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Disclosure to Release Protected Health Information form before we will disclose your health information.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Witness (Physical Therapist)

A photocopy of this agreement is to be considered valid, the same as if it was the original.

BioDynamic Manual Therapy, LLC

AUTHORIZATION TO RELEASE INFORMATION

Date _____

Name_____

DOB_____

Address_____

Home Phone _____Work Phone_____

Effective Date_____

I, _____, authorize *BioDynamic Manual Therapy, LLC* to release the following information_____

_____to:

- _____ (Name/Relationship)
  Who can be contacted at _____
- _____ (Name/Relationship)
  Who can be contacted at _____
- _____ (Name/Relationship)
  Who can be contacted at _____
- _____ (Name/Relationship)
  Who can be contacted at _____

This authorization will be in effect for _____days, not to exceed 12 months.

I have the right to revoke this authorization at any time by submitting the revocation request in writing to *BioDynamic Manual Therapy, LLC* and signing below.

_____ _____

Signature of Agreement Date

_____ _____

Signature of Revocation Date