Bodywork for Wellness,
Manual Physical Therapy & Therapeutic Massage, PLLC

Welcome to Bodywork for Wellness! I am pleased to be a part of your healing journey. Below is a letter describing my current policies. Please read it fully and carefully, should you have any questions I will be happy to answer them.

Your first visit: will last approximately 75 minutes where a complete medical history will be taken and evaluation will be performed for either Physical Therapy or Therapeutic Massage. Once the evaluation is completed the remainder of the session will include treatment using the type of therapies or massage that I provide.

Under the New York State Education Law, a physician's prescription or referral is not needed for the first 30 days or 10 sessions of physical therapy treatment. Once the 30 days has expired a prescription is REQUIRED. Some insurance companies require one from the onset of therapy for out of network benefits to be paid. It is helpful to obtain a script from your doctor prior to starting therapy, if you do not have a prescription prior to starting treatment we can begin and you will be asked to facilitate the process. Should you not obtain a prescription prior to the 30 day mark you sessions will be canceled until a prescription is obtained.

Fees: Please refer to website www.bodyworkforwellness.com for most up to date pricing. Initial evaluations for Physical Therapy or Therapeutic Massage sessions are a 75 minute session and all follow up sessions are 60 minutes. Payment, in the form of check, cash, or credit card is requested at the time of each visit. Fee for insufficient funds for payments is $35

Reimbursement: At this time I am not a participating provider with any insurance companies including no fault and workers compensation. Most HMO's consider my services an 'Out Of Network' provision of physical therapy. If your health insurance allows you to submit bills to them for reimbursement or allows you to see an out of network physical therapist, you may receive reimbursement for my fees. I can provide you with the necessary documentation in the form of receipts to assist you in receiving reimbursement from your health insurance company. Due to the complex nature of insurance claims and reimbursement, I make no promises as to whether you will receive reimbursement. Due to focus of my practice on treatment I do not write letters or fill out forms for justification of treatment. Also I do not accept patients who are actively in or anticipate being in litigation related in any way to any injury or body area that my physical therapy services may address during the course of treatment. Lastly, receipts for employer based flexible spending programs are also available upon request.

PLEASE NOTE: Since Myofascial Release is a hands-on technique; I request that you bring appropriate clothing to facilitate this process. Women are asked to bring a sports bra, bathing suit top, or tank top along with a loose fitting pair of shorts of a thin material (not denim shorts, please) or bathing suit bottom. A very loose fitting T-shirt can be worn if necessary, though bring one that you do not mind the potential of it becoming stretched out. Attire for Men is a pair of loose fitting shorts ie gym shorts. For therapeutic massage you will be undressed to you level of comfort and covered with a sheet and blanket. If you have specific concerns in this area, do not hesitate to let me know.

I ask that you not wear any body lotion or oils on the day of your evaluation or subsequent sessions. Also please refrain from wearing strong perfumes, colognes or shave lotions as some can be sensitive to strong smells.

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What to expect: I view our treatment as a partnership, and with that you always get my best skills to date, as I continue to add to my training multiple times per year. As the client and a partner in your own health care, there is a need for a level of dedication and compliance to therapy to allow us the best opportunity to reach the maximal desired goals and outcomes. Therefore, it is essential that compliance with advised frequency of sessions, home exercises/self treatment, communication, and any other therapist recommendations all be recognized and implemented to the highest possible level during your care. Lack of any of these components may hinder your progress. Participation in therapy is not a guarantee of results.

An appointment is a commitment to our work and a contract between us. In order for all of this to work, you need to be on time for your appointment. If you arrive late, your session will need to end at its originally scheduled time with the fee equal to the original length of the scheduled session. On occasion, I may not be able to start on time. This is usually because a treatment is taking slightly longer than expected. For this I ask for your understanding and assure you that you will receive a full treatment. Also, be assured that at some point if you need a longer session, you will always be afforded the same consideration. If you need to cancel, please call as soon as possible, **24-hour notice is required for cancellations to avoid payment of the full session fee. During weeks of holidays, 48 hours' notice is required to avoid a full session fee.**

Scheduling: Please refer to my website for the most up to date hours of operation. All appointments must be made in person at the time of your session or by phone. Often it is necessary to have several visits to determine that the care offered at Bodywork for Wellness is a match to your needs for therapy. In honor of your commitment, time, and resources, after 3-4 visits your care plan and results of treatment will be discussed with your therapist and a determination will be made if further therapy sessions are indicated, or if referral to another level or kind of care is in your best interests. My skill set provides relief and results for most clients but this work is not always the best tool for every client. In my experience, if I feel that I can not further assist you I will always let you know and make an appropriate referral.

Contacting Me: Since each session is one on one and focused attention to your care is vital, I do not take phone calls during treatment sessions. Therefore, if you need to reach me it is best to call and leave a voicemail, email is also acceptable. I check messages and emails as often as I can and will always return calls as promptly as possible, typically that day, but not longer than 24-48 hours. I always have access to my voicemail so you may call and leave a message even when I am out of the office.

I acknowledge that I have read or have had read to me the above information about treatment. I have had the opportunity to ask questions about its content. I am aware that I have the right to refuse any form of treatment at any time, and that no guarantees can be made concerning the results of treatment. My signature below represents my consent to treatment of my present condition and any future conditions for which I seek treatment.

______________________________________ ________________

Patient Signature Date

____

Therapist Signature

Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Bodywork for Wellness, Manual Physical Therapy & Therapeutic Massage PLLC, 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 and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number 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 or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. 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 phone, voicemail, email or text. Bodywork for Wellness, Manual Physical Therapy & Therapeutic Massage PLLC will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I consent to ALL Communication including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all you consent to):
  - Email
  - Text
  - Voicemail
- ☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all you consent to):
  - Email
  - Text
  - Voicemail
- ☐ I do NOT consent to any communication

E-mail address you are consenting to communicate through: ____________________________________

Phone number you are consenting to communicate through:____________________________________

Patient Signature: ____ Date________________

Authorized Representative/Guardian Signature:___________________________ Date________________

Payment Agreement

Thank you for choosing Bodywork for Wellness, Manual Physical Therapy & Therapeutic Massage, PLLC (doing business as "Bodywork for Wellness") as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- 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.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **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. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **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 Authorization 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: ___________________________

Signature of Provider Representative

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

Bodywork for Wellness,

Manual Physical Therapy & Therapeutic Massage, PLLC

1 Pine West Plaza, Suite 111, Albany, NY 12205
Ph: 518-424-6487

Name ______________________________ Work Phone____________________
Address_____________________________ Home Phone____________________
____________________________________ Cell Phone ______________________
Date of Birth___________________
Occupation____
Are you currently working? _______________________
Emergency Contact Name/ Number____

Would you like to be included in our Quarterly Newsletter/email list? YES NO

Email____

ALLERGIES____

Diagnosis____

Referring Physician's or Primary Physician's Name_______________________________

Physician's Phone________________________________

How did you hear about Bodywork for Wellness and/or Jennifer Catino, MPT/LMT?
____

Bodywork for Wellness,

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HIPAA Signature Form

I, _______________________________, acknowledge that I have had the opportunity to read and understand the **NOTICE OF PRIVACY PRACTICES** from Jennifer Catino, MPT, LMT/Bodywork for Wellness, 1 Pine West Plaza Suite 111, Albany, NY 12205, that is listed on her website on _________________.

I give permission for Jennifer Catino, MPT, LMT/Bodywork for Wellness to communicate with the following people:
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

____
(Patient Signature)

Bodywork for Wellness
Manual Physical Therapy and Therapeutic Massage, PLLC
1 Pine West Plaza, Suite 111, Albany, NY 12205
PH: 518-424-6487

Name______________________________ DOB____________________
Address____________________________ Date____________________
____

Reason Bringing you to Physical or Massage Therapy?_______________________________________
____
____

How Long Have you Been With This Complaint?____

Have you had this or similar pain before? (if yes, when, please describe)__________________________
____

Are you Currently Under the Care of a Doctor for this? ___________________________

Please List Current Medications, including supplements and over the counter drugs_________________
____
____

Please List anything that Increases or Decreases your Complaints
Increases____
Decreases____

List ONE Activity you are unable to do, that you want to do again_______________________________

In your understanding, what will make this better?____

How optimistic are you about getting better? Not at all….Mildly optimistic,…Fairly….Very optimistic

What are some potential obstacles to you getting better?_______________________________________

List any previous Surgeries, Accidents or Injuries ____
____
____

Over the next 30 days how many hours per week will you commit to getting better?______________

Circle your worst pain level in the last couple days Mild Moderate Severe
0….1….2….3….4….5….6….7….8….9….10

Goals for Treatment/What are you expecting from therapy?_________________________________
____

Name________________________________ DOB_________________

Please **Circle** any of the following conditions that you **currently have.** Please * conditions you have had in the past

Musculoskeletal
Bone or Joint Disease
Tendonitis
Bursitis
Broken/Fracture Bones
Arthritis
Sprains/Strains
Low back, hip, leg pain
Neck, shoulder, arm pain
Headaches
Spasms/ Cramps
Jaw Pain
Lupus
Osteoporosis
Other_______________________

Respiratory
Breathing Difficulty
COPD/Emphysema/Asthma
Allergies
Sinus Problems
Other_____________________

Skin
Scar and Location________________________
Rashes
Skin Hypersensitivity (RSD/CRPS)
Athlete's Foot
Warts
Other______________

Circulatory
Heart Conditions
Heart Attack History
Congestive Heart Failure
Carotid Stenosis
Aortic Aneurysm
High Blood Pressure
Low Blood Pressure
Blood Clots
Lymphedema
Varicose Veins
Other____________________

Nervous System
Numbness/tingling
Chronic Pain
Herpes/Shingles
Sleep Disorders
Polio/Post Polio
Multiple Sclerosis
Parkinson's disease
Cervical Dystonia
Muscular Dystrophy
Other______________

Reproductive
Bloating
Cramps/Pain
Mood Swings
Breast Tenderness
Endometriosis
IUD
Fibroids
Polycystic Ovarian Disease
Hysterectomy
Painful Periods
Irregular Periods
Peri/Menopausal Symptoms
Pregnancy…# of weeks_____
Other___________________

Digestive/Urinary
Irritable Bowel Syndrome
Crohn's Disease
Gas/Bloating
Diverticulitis
Constipation
Diarrhea
Lack of Urine
Kidney/Bladder Infection
Renal Insufficiency
Urinary Frequency/Urgency
Incontinence/Leakage
Prostrate Enlargement
Other_____________

Name________________________________ DOB_________________

Other

Fever/ Infection
HIV/AIDS
Headaches/Migraines
Head Injury
Cancer/Tumors
Diabetes
Thyroid Hypo/Hyper
Eating Disorders
Depression
Anxiety
Fatigue
History of Abuse (physical or sexual)
Hearing/Vision Loss
Other____________________________

☐ Please check here if there are items on this form that you have not marked but apply, and that you would rather discuss with the therapist

It is my choice to receive therapy (massage or physical) at this time. I have identified all applicable conditions, all of this information is true, and I will notify my therapist of any medical changes as they occur. I will not hold the therapist responsible for any conditions that were not disclosed. I agree that it is my responsibility to notify my therapist if I need changes in pressure or if I am not comfortable at any time with any technique, and that either party may stop the session at any time if the need occurs.

Signature______________________________________ Date___________________