Pain-Free Solutions

Date_____

First Name_____ Last Name_____ MI_____
Address_____ City_____State____ ZIP_____
Age_____ Date of Birth_____
Phone_____ Work_____ Cell_____
Email_____ Occupation_____Employer_____
Spouse_____ Phone_____ How did you hear about us?_____

Contact in case of emergency_____ Phone_____Relationship_____

Insurance Company_____Address_____Claim #_____Referred by Dr_____
Please allow the receptionist/therapist to copy your insurance card / auto accident information / work accident information

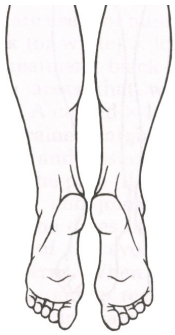
If auto or work injury, Date of Injury_____ First Doctor Appt_____
Any dates unable to work? From___/___/___ to ___/___/___If work injury, Employer at the Time of Injury _____

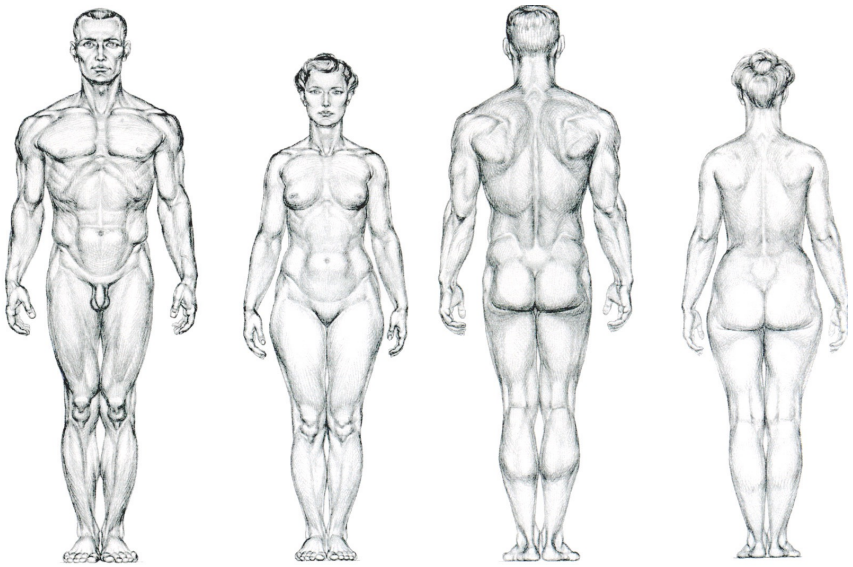
What is your major complaint?_____
How intense is it on a scale of 1-10? (10 being worst imaginable)_____
When did this condition first develop?_____
How often does it bother you? 100%-75%-50%-25% of the time_____
Is this the first time?_____
What caused this condition?_____
What makes it worse?_____
Has the problem been getting worse, better or staying the same?_____
What have you done to help it?_____
Are you currently under the care of a doctor, chiropractor or physical therapist for this problem?
Please explain_____
Other Doctors' or providers' recommendations_____
_____
Other complaints?_____
_____
Other health issues? (Even if unrelated)_____
Are you currently taking medication? Please list_____
What kind of exercise do you engage in regularly?_____
Surgeries/Major Illnesses_____
Please circle the word that best describes your current level of stress:
Mild Moderate Severe
Please describe the outcome you wish to achieve with this session/therapy_____
_____

On the figures to the right, please **circle** the location of any **pain and/or limitations**.

If possible, describe your condition with the following abbreviations:

P = Pain
B = Burning
T = Tingling
A = Aching
N = Numbness
S = Stiffness
H = Headaches
BR = Bruise
⊣⊢⊣ = Scar





ACTIVITIES OF DAILY LIVING: Please **circle** the activities that are causing you **pain or limitations**:

Hygiene and Grooming: Showers Bathing Hair Tasks Dressing-Upper Body Dressing-Lower Body Toilet Shaving Other_____

Homemaking Tasks: Cleaning Lifting Push-Pull Tasks Child Care Yard Work Reaching-Low Reaching-High Other_____

Transfers: Bed Bathtub Car Chair On-Back Side

Endurance: Please circle in HOURS your ability to perform the following tasks:

Driving:	1/4	1/2	3/4	1	2	3	4	5	6	7	or More	Comments:_____
Sitting:	1/4	1/2	3/4	1	2	3	4	5	6	7	or More	Comments:_____
Sleeping:	1/4	1/2	3/4	1	2	3	4	5	6	7	or More	Comments:_____
Standing:	1/4	1/2	3/4	1	2	3	4	5	6	7	or More	Comments:_____
Walking:	1/4	1/2	3/4	1	2	3	4	5	6	7	or More	Comments:_____

Work Restrictions?_____

Please take a moment to read the following information and sign where indicated.

If you have a specific medical condition or specific symptoms, Active Release Techniques® Soft Tissue Treatment (ART®), Neuromuscular Therapy (NMT), Myofascial Release (MfR), Massage, or other forms of muscular therapy may be contraindicated. A referral from from your primary care provider may be required prior to service being provided. A Superbill will be provided to you upon request as long as you have a prescription by your Primary Care Provider. This prescription must include CPT codes and diagnostic codes from your doctor.

"I understand that the therapy I receive is for the basic purpose of relieving muscular tension. If I experience any pain or discomfort during this session, or sessions that follow, I will immediately inform the practitioner. I further understand that ART® Soft Tissue Treatment, NMT, MfR, Massage, or other forms of muscular therapy performed from this office should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any physical or mental ailment that I am aware of. I understand that a massage practitioner cannot make a diagnosis. Because muscular therapy should not be performed under certain conditions, I affirm that I have state all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so.

I will be liable for payment of each scheduled appointment. If I am unable to keep my appointment, I will notify the office 24 **hours** prior to the appointment. Appointments which have not been canceled will be billed **directly to me at 100%** of the normal rate. My insurance will not be responsible for these charges.

Consent: I, the undersigned, hereby authorize the staff of Pain-Free Solutions to examine and perform procedures that are considered therapeutically necessary on the basis of findings during the initial exam and the course of treatment."

Signature_____Date_____

Practitioner's Signature_____Date_____

Pain-Free Solutions
Financial Policy

Plan #1 - INSURANCE: If you have insurance that includes Massage Therapy benefits, we will bill your insurance as a service to you. Most patients have a deductible and co-pay to meet for their insurance plan. Our office policy requires all insurance billed visits to have a prescription from your primary doctor (MD or ND), chiropractor or specialist. (Most insurance plans require this.)

Plan#2 - SELF-PAY: Fees are due at the time services are rendered. We accept cash, check, Visa, MasterCard, and debit cards.

Plan #3 - WORK INJURY: You need to report your accident to your employer and complete the proper forms. Please bring in the insurance information. You are required to have a referral or prescription from your treating doctor.

Plan#4 - AUTOMOBILE ACCIDENT INJURY: For an active PIP claim, you need to supply us with the car insurance information (yours or the liable party's), including adjustor's phone number and claim address, claim number, attorney information if applicable and your back-up health insurance information. If there is no active PIP coverage, or you are awaiting settling your claim to cover medical bills, you will be required to make a $50 per session deposit. The outstanding bills will be sent to your attorney to be paid at the time of settlement. If there is no settlement or no payment occurs, you will be responsible for payment for the balance amount for services provided to you. You are required to have a prescription from your treating provider prior to treatment.

All patients, with or without insurance, are responsible for payment at the time of service. We accept Cash, Check, VISA, MasterCard and most Debit Cards. Interest at the rate of 1% per month will be added to balances over 30 days. Agency fees will be added to all accounts that are turned over for collections.

A $25 fee is applied to NSF checks.

I have read the above financial information. Initial_____

Insurance Coverage?

If we are contracted with your medical insurance plan, it is possible they may cover your visits at our clinic. However, each insurance plan is different. It is our office policy that a prescription from your referring provider is required to bill your insurance.

Active Release Techniques treatment falls under massage therapy benefits. **Please contact your insurance company by calling the customer service phone number on your insurance card.** Here are the questions you should ask:

- **Do I have massage therapy benefits?**
- **Is treatment covered by a Licensed Massage Practitioner (LMP)** (There are a few plans that will only pay for this treatment by a chiropractor or medical doctor.)
- **Do I have a deductible? Have I met it yet?**
- **Is there a limit to the number of visits I can receive?**
- **Is there a maximum dollar amount per year that my plan will pay towards this treatment?**
- **What percentage does my insurance cover?**
- **Do I have a copay for each visit?**
- **Do I need a referral from my doctor, or am I a part of a Preferred Provider Organization-PPO?** (A prescription and a referral are NOT the same thing. There are very few insurance companies that do not require a prescription, and again, a prescription is required by our office.)

Knowing the answers to these questions can prevent any misunderstanding of your benefits and unexpected bills. If we are not contracted with your insurance plan, you may still have some limited benefits. In addition to the above questions, you should also ask: **Do I have out-of-network benefits for massage therapy?**

PATIENT AGREEMENT

My signature below signifies that all information I have provided is true and correct to the best of my knowledge.

Release of Records: To Pain-Free Solutions: I hereby authorize you and your chosen medical billing service, to release to any attorney, physician, State Insurance Commissioner, or insurance company involved in my case, any medical or other records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/illness sustained on (date) ___/___/___ (if applicable).

Assignment of Benefits: I, the undersigned, request that payment of authorized insurance benefits be made on my behalf to Pain-Free Solutions or the designated Provider for any services provided to me by that organization.

Financial Agreement: I understand that my insurance policy (if applicable) is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment.

I agree and acknowledge that I am ultimately responsible to you for payment of any balance due, including copays, unpaid deductible and/or unpaid percentage amounts due to you according to my policy coverage in the event you are unable to collect from my insurance carrier, or attorney in the case where you are holding an attorney lien on my behalf.

I hereby authorize Pain-Free Solutions to charge all past due balances denied by or unpaid by my insurance company to my credit or debit card listed below.

Credit/Debit card company_____ / VISA / MASTERCARD

Name of cardholder as it appears on the credit card_____

Credit card number_____Expiration Date_____

Cardholder Signature_____3 digit security code_____

Receipt of Notice of Privacy Practices: My signature below indicates I have reviewed a copy of Pain-Free Solutions Notice of Privacy Practices. (PAGE 5)

Communications: Do we have permission to:

Leave a message on your voicemail/ answering machine/ cell at home? ☐ Yes ☐ No

Leave a message on your voicemail/ answering machine/ cell at work? ☐ Yes ☐ No

Communicate by email? ☐ Yes ☐ No Email address:_____Communicate by mail? ☐ Yes ☐ No

i.e. Other than invoices for billing; including greeting cards, newsletters

Invoices of any unpaid balance will be sent via email unless otherwise requested.

Discuss your medical condition with any member of your household? ☐ Yes ☐ No

If yes, whom? _____ Relation: _____

I agree to the preceding **Financial Policy** and qualify for Plan # 1 / 2 / 3 / 4. (Circle one)

I agree to the preceding **Patient Agreement.**

I have been given the opportunity to read the preceding **Patient Agreement** form, to ask questions concerning it, and have received an adequate explanation of it.

I have received a copy of this agreement, including the questions to ask my insurance company. **I understand that Pain-Free Solutions suggests I contact my insurance company to verify my benefits.**

PRINT PATIENT'S NAME (or guardian if a minor) _____

PATIENT'S SIGNATURE (or guardian if a minor) _____DATE_____/_____/_____

Pain-Free Solutions

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The Health Insurance Portability & Accountability Act of 1996 (HIPAA) required all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or verbally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As require by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and heath care operations. Treatment mean providing, coordination, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a health insurance plan for your medical services. Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment. Unless you request otherwise, we will not disclose any protected health information to family members, friends, personal representative, or to any other individual. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order as required by law, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence, to the Food and Drug Administration (such as to report adverse drug events), Worker's Compensation claims, and business associates, such as medical transcriptions services, with whom we contract for services. We require these business associates to protect the confidentiality of your health information. Any other uses and disclosures will by made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below. You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. You have the right to receive confidential communication of protected health information from us by alternative means or at alternative locations. You have the right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed. You have the right to request an amendment to your protected health information. We may, however, deny your request in certain situations. Detailed requests for amendments must be submitted in writing. You have the right to receive an accounting of disclosures of protected health information made outside of treatment, payment, health care operations or based on your previous authorization. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of 12/12/06, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our privacy practices please contact:

Pain-Free Solutions
2735 California Ave SW #1A
Seattle, WA 98116
206.937.3098

For more information about HIPAA or to file a complaint please contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
877.696.6775