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

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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, however some insurances require one. 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 I will do my best to assist you in obtaining a prescription from your doctor. You may be asked to facilitate the process as well. Frequency of treatment will be determined at your evaluation session with input from you and your physician as well.

**Fees:** Initial evaluations for Physical Therapy or Therapeutic Massage sessions are $125 for a 75 minute session, all follow up sessions are 60 minutes and are charged at $105 per session. Payment, in the form of check, cash, or credit card is requested at the time of each visit.

**Reimbursement:** At this time I am not a participating provider with 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 will 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. 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 having stretched out. Men are usually comfortable in just a pair of loose fitting 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

An appointment is a commitment to our work and a contract between us. 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. 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. 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.**

**Scheduling**: 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. I check messages as often as I can and will always return calls as promptly as possible. I always have access to my voicemail so you may call and leave a message even when I am out of the office. I do not accept text messages for any reason. I do not have internet access in my office so if you choose to contact me by email please know that I will not be able to respond to emails until the end of the day.

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

# NOTICE OF PRIVACY PRACTICES (MEDICAL)
# 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") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act 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 required 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 information.

We may use and disclosed your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtained reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be 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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

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 **December 1st, 2003** 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

**For more information about HIPAA or to file a complaint:**
The U.S. Department of Health & Human
Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

# Bodywork for Wellness,

## Manual Physical Therapy & Therapeutic Massage, PLLC

I, ___________________________________, acknowledge that I have received and understand the **NOTICE OF PRIVACY PRACTICES** from Jennifer Catino, MPT, LMT/Bodywork for Wellness, 350 Northern Blvd Suite 305, Albany, NY 12204 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 & Therapeutic Massage, PLLC

350 Northern Blvd, Suite 305, Albany, NY 12204
Ph: 518-424-6487 Fax: 518-463-3020

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Name ______________________________ Work Phone____________________
Address______________________________ Home Phone____________________
_____________________________________ Cell Phone ______________________
Date of Birth____________________
Occupation__________________________________________________________________
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?
___________________________________________________________________________

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***Please be advised that all appointment scheduling must be done in person or by phone and there is a 24 hour cancellation policy, any cancellations given with less than 24 hours notice may incur a full session charge.

I am aware that services provided by Bodywork for Wellness, Manual Physical Therapy and Therapeutic Massage, PLLC are provided on a fee for service basis, and that payment is to be rendered at the time of treatment. It is my responsibility as the patient to submit for out of network insurance reimbursement (if my policy allows) with codes/receipts provided by Bodywork for Wellness Manual Physical Therapy and Therapeutic Massage PLLC.

I also understand that while Physical Therapy services are now available in NY for 10 visits or 30 days without a referral from a physician, dentist, podiatrist, or nurse practitioner that any treatment I receive may not be covered by my health care plan or insurer without a prescription if I submit for out of network benefits. **The treatment start date is the date at bottom of this form and that, after 30 days or 10 visits whether or not I am submitting to insurance; a prescription for physical therapy for PT services provided will be required by NYS law.**

There is a $35.00 service fee for checks with insufficient funds.

All of the above information is true to the best of my knowledge, and I have read and agree with the policies above, and I have been provided with an opportunity to review the HIPAA policy.

Client's Signature__________________________________________ Date____________

Therapist's Signature________________________________________ Date_____________

Bodywork for Wellness
Manual Physical Therapy and Therapeutic Massage, PLLC
350 Northern Blvd, Suite 305, Albany, NY 12204
PH: 518-424-6487    Fax: 518-463-3020

Name______________________________ DOB____________________
Address____________________________ Date__________________
__________________________________

Reason Bringing you to Physical or Massage Therapy?___________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

How Long Have you Been With This Complaint?________________________________
__________________________________________________________________________

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_________________________________________________________________

Please List any previous Surgeries, Accidents or Injuries __________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Goals for Treatment_______________________________________________________

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_____________

***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____________________