RONALD S. MURRAY PT

(240) 492-8434 Fax (240) 489-8434
10005 Old Columbia Rd. #P170, Columbia, MD 21046
5411 W. Cedar Lane, #202A Bethesda, MD 20814
2311 M Street NW #301, Washington DC 20037
Website: www.ronmurraywellness.com
Email: rsmpt@asclepeion.com

Dear New Patient,

We want to welcome you to RSM Physical Therapy/ Asclepeion Center and to tell you a bit about our training, the way we work, and our philosophy regarding health and healing. We also want to inform you of the cost of our services and our billing procedure.

We are trained not only in traditional methods of physical therapy, but also in various new techniques aimed at (1) gently freeing any areas of restricted movement in the body and encouraging the natural healing abilities of the body to return to its optimal functioning level and (2) helping individuals to explore any psychological, as well as physical components of their pain syndromes and/or disease processes. We have enclosed information and brochures that will give you a beginning sense of the work that we will be doing together.

Our professional mission is to provide a comprehensive evaluation and treatment protocol that will address not only the physical causes of your problem, but also any emotional components as well. We have found in our work that there is almost always a somato-emotional component to intractable health problems, chronic and acute pain syndromes, and deeply ingrained patterns of muscular tension. We make every effort to provide a safe space for our patients within which they can face and release any emotional trauma that has caused them to develop rigid pain-producing patterns of muscular tension.

Our fee for an initial visit is $170, with a $20 courtesy extended ($150). We also strongly suggest each patient undergo a "Heart Rate Variability Analysis" (HRV). The HRV is a non-invasive test that takes about 10 minutes to administer. It's an excellent indicator of general health and the health of the nervous system. The fee for this test is $75.

The cost of ongoing sessions is $150, with a $20 courtesy extended ($130). All of our treatments are insurance reimbursable (based upon your policy). As a courtesy, we will be glad to submit insurance claim forms for you and note that the reimbursement should be sent directly to you.

In order to expedite our initial meeting, please fill out the enclosed Patient History Form and bring it to your first visit. Be sure to fill it out in detail so we have a full sense of your medical history and past treatment. If you would like for us to submit the insurance claims for you, please complete the insurance information page, also.

In closing, we would like to say that we believe a person with chronic pain and/or health problems recovers faster when actively participating in the healing process. The focus of our work is to help you "listen to your body's needs" so you can then help it to reclaim its natural healing potential. During the time that we work together, we urge you to become your own co-therapist deciding, with our help and input of course, what blend of treatment modalities works best for you. We look forward to meeting with you and beginning our work of bringing greater health and healing into your life!

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PATIENT HISTORY FORM

Date Today: _____ **Referred by:** _____

Name: _____

Address: _____ **Apt Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____**Fax Number:** _____ **Email:** _____

DOB: _____ **Marital Status:** _____ **Occupation:** _____

Internist: _____ **Phone:** _____

Please list all medications that you are presently taking (use back if necessary):

_____ _____

_____ _____

_____ _____

_____ _____

Please list all known allergies (use back if necessary):

_____ _____

_____ _____

_____ _____

Please list all surgeries with dates (use back if necessary):

_____

_____

_____

_____

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Please indicate if you have had any of the following tests (circle test and then date):
X-ray Date_____ MRI Date_____ TOMO Date _____CAT Scan Date _____ EMG Date_____

Others with Name and Date (use back if necessary): _____

_____

_____

What are your specific complaints? From what symptoms do you most desire relief?
Fill in date that you first experience d each problem that you are seeking help for?
Please list from the most to least important:

1. _____**Date**_____ **4.** _____**Date**_____

2. _____**Date**_____ **5.** _____**Date**_____

3. _____**Date**_____ **6.** _____**Date**_____

Under what circumstances did the pain begin? (Please check all that apply.)
___ Accident at work ___ Accident at home ___ Other Accident ___At work, but not an accident
___ Following Surgery ___ Following illness ___ No Event ___ Other Reason or circumstance please explain:

_____

_____

_____

_____

_____

Level of Pain
On a scale of 0 to 10 (with 0 being the lowest level of pain) please circle on the scale on the next page where your pain level today falls on the scale.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

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Please list all medical practitioners that you have seen for this problem (use back if necessary):

_____ _____

_____ _____

_____ _____

Please describe any other pertinent information, symptoms, disorder, etc. not yet covered.

_____

_____

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Thank you so much for taking the time and effort to fill out this Health History Form.

Signature _____ **Date**_____

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INSURANCE BILLING AND PAYMENT POLICY

Name: _____

Address: _____**Apt Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____**Work Phone:** _____

Birth Date: _____**SS Number:** _____

Referred By:

_____

(If being treated in WDC a referral to PT from a physician is required by law)

Date of Onset of Illness: _____

Insurance Company Name: _____ **Policy #:** _____ **Group #**_____

Ins. Co. Address: _____ **DOB:** _____

Ins. Co. City/State/Zip: _____**Phone #**_____

Insured Name (if different): _____ **Insured DOB:** _____

Insured's Employer: _____

I understand and agree that all treatments are to be paid in full to RSM PT, Inc. at the time of treatment. I also understand that RSM PT, Inc. will prepare any necessary file information to assist me in being reimbursed by my third party payer. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all costs of my treatments at this facility. I also understand that if I suspend or terminate my care, any fees incurred prior to my formal discharge by RSM PT will be immediately due and payable in full, unless RSM PT has entered into some other written and signed agreement with me. I also understand and agree that I will be responsible for any fees incurred in the collection of my past due accounts, including but not limited to, attorney fees and court costs, as well as any other reasonable charges.

Patients Signature: _____ **Date:** _____

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INFORMED CONSENT FOR TREATMENT AND/OR EVALUATION
Minor CLIENT

I, _____, of _____, _____
Parent Name Child Name Minor DOB
hereby give my permission and consent for treatment at the RSM PT/Asclepeion Center for Body Mind Therapy. I understand that this may include the intake and diagnostic assessment process as well as may therapies that may be recommended or prescribed.

I have been informed that staff members at the RSM PT/Asclepeion Center for Body Mind Therapy consult with one another for purposes of consultation, collaboration, and supervision. I also consent that the RSM PT/Asclepeion Center for Body Mind Therapy can us and disclose Protected Health Information for treatment, payment and healthcare operations.

I understand that all assessment or treatment and evaluation is voluntary, and that treatment will end:

- **When the therapist and I decide that sufficient progress has been made.**
- **At any time I so choose.**

I have read and/or had the above explained to me, and voluntarily give my informed consent to treatment and/or evaluations.

_____ _____
Client Signature Date

_____ _____
Clinician/Witness Signature Date

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NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT:

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of RSM PT/ Asclepeion Center. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our *Notice of Privacy Practices* is subject to change.

If you have any questions about our *Notice of Privacy Practices*, please make the front office staff aware.

I acknowledge receipt of the *Notice of Privacy Practices* of RSM PT/Asclepeion Center.

Patient's Name: _____

Signature: _____

Date:_____

Please circle one: *(patient / parent / conservator / guardian)*

INABILITY TO OBTAIN ACKNOWLEDGEMENT:

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient's Name:_____

Reasons why the acknowledgment was not obtained:

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

Other:_____

_____

Signature of provider representative:
_____Date:_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU AND/OR YOUR CHILD'S TREATMENT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

RSM PT/Asclepeion Center for Body Mind Therapy is committed to preserving the confidentiality and privacy of all individuals served. In accordance with federal guidelines stipulated in the Health Insurance Portability and Accountability Act (HIPAA), RSM PT/Asclepeion Center for Body Mind Therapy is updating and notifying you in writing about our practices concerning confidentiality, your health information rights and the use and disclosure of our medical records. It is important to us that you know deeply we value the trust you have placed in us. As part of earning and keeping that trust, we want to emphasize that respecting your privacy and keeping the confidentiality of your personal information is a serious matter for everyone associated with our center. We have therefore kept in place many of the safeguards we have long used to protect your confidentiality. Moreover, we have added additional policies and practices.

We understand that health information about you and the health care you receive is personal and we are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you have received. We need this record to provide you with quality care and to comply with legal and/or billing requirements. This notice tells you about the ways in which we may use and disclose this Protected Health Information (PHI). This notice also describes your rights with respect to the medical and/or psychological information that we keep about you and the obligations that we have when we use and disclose this information.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Your Protected Health Information (PHI) is the individually identifiable information in any form (oral, written or otherwise) that relates to your past, present or future physical and mental health. Use applies to activities within RSM PT/Asclepeion Center such as sharing, employing, applying, utilizing, examining, and analyzing information about you. Disclosure applies to activities outside of the Center, such as releasing, transferring, or providing access to information about you to other parties.

We use and disclose your Protected Health Information (PHI) in the following manner:

1. We may use/disclose protected health information without written authorization when we use that information for treatment, payment, or the health care operations of the Center:

    - We will use medical record information for treatment. For example, information provided by family, physicians or other professionals might be recorded in your medical record and used to determine the best course of treatment. We might disclose PHI to a pharmacy when we order a prescription. In addition, many of the people who work in the Center may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care such as your caretakers or family.

    - We will use medical record information for payment. For example, we may contact your health insurance carrier to certify that you are eligible for benefits. Additionally, a bill may be sent to you or an insurance carrier or to the person responsible for your bill. This bill will contain information related to diagnosis and services provided on a particular date. We may also, on

occasion, be required to submit additional information regarding your progress in treatment to an insurance carrier in order to obtain payment for services rendered.

- We will use medical record information for regular health operations. For example, we may use certain Protected Health Information to assess the quality of care and treatment outcomes. This information will then be used in an effort to continually improve the quality and effectiveness of the services provided by the Center. PHI could also be used for business-related matters such as audits and cost management or business planning activities for the Center.

2. You may authorize RSM PT/Asclepeion Center to disclose specific Protected Health Information to a specific person/agency.

    - If you request that information be shared with others, we will supply you with an Authorization Form for that purpose.

    - An authorization will also be obtained from you before we would release any Psychotherapy Notes. Psychotherapy Notes are notes your therapist may have made about your conversations during an individual, group, joint or family counseling session and, if made, are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

    - Subsequently, you may revoke an authorization at any time provided that each revocation is in writing.

3. We are required by law to disclose Protected Health Information in certain circumstances.

    - To report Child, Adult or Domestic Abuse and Child Neglect. If we know or in good faith suspect that any child under the age of eighteen and/or any elderly/disabled/incompetent adult has been abused or is placed at imminent risk of serious harm, then we must report this suspicion or belief to the appropriate authority.

    - For Heath Oversight Activities. We may disclose your PHI for health oversight activities authorized by law. Oversight activities may include, for example, investigations, inspections, surveys, audits, licensure and disciplinary activities or activities necessary for the government to monitor governmental programs, compliance with civil rights laws and the health care system.

    - To report Serious Threat to Health or Safety. If we believe in good faith that there is risk of imminent personal injury to you or to other individuals or risk of imminent injury to the property of other individuals, the appropriate information, as permitted by law, may be disclosed.

    - To comply with laws around Worker's Compensation. We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relation to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

    - For Judicial and Administrative Proceedings. We may disclose information in a medical record in response to a valid subpoena unless covered by privilege. You will be notified if such a subpoena has been received by this agency and the extent to which it has been acted upon. We will not disclose privileged information without a written authorization from you or your legally appointed representative or a court order. Privilege does not apply when you are being evaluated

when the evaluation is court-ordered. You will be informed in advance if this is the case.

- To contact you. We may also disclose information in order to contact you, for example to make appointments, to check with you about how you are doing, and/or to evaluate the services that we provide to you and/or your child.

YOUR HEALTH INFORMATION RIGHTS:

1. Right to Inspect and Copy:

   You have the right to inspect and copy the personal medical and psychological information in medical and billing records used to make healthcare decisions about you for as long as the PHI is maintained in the record (at least 6 years).

   - This right does not include the right to inspect and copy psychotherapy notes, although we may, at your request, talk to you about them.

   - To inspect and copy the personal medical and psychological information in your medical or billing records, you must submit your request in writing to our privacy contact person Martha Bramhall. If you request a copy of the information, we may charge a fee for the copying and mailing costs, and for any other costs associated with your request.

   - We may deny you access to PHI under certain circumstances, but in some cases you may have this decision reviewed by our Privacy Officer, Martha Bramhall. At your request, we will discuss with you the details of the request and denial process.

2. Right to Amend:

   - If you disagree with the contents of your medical record, you may request an amendment to that record.

   - If we believe the existing record is accurate and complete and/or if you are requesting amendments to parts of the record that we did not create, we will deny the amendment and give you specific reasons for the denial. At your request, we will discuss with you the details of the amendment process and the process of appeal.

3. Right to an Accounting of Disclosures:

   You also have the right to obtain an accounting of disclosures of Protected Health Information made to others other than for treatment, payment, and healthcare purposes or for which you did not give written authorization. Additionally, you may revoke your authorization to use or disclose information. At your request, we will discuss with you the details of the amendment process and the process to obtain an accounting of disclosures.

4. Right to Request Restrictions:

   You have the right to request restrictions on certain uses and disclosures of medical record information for treatment, payment, or regular health care operations. We will carefully consider your request, although we are not required to abide by your request. If we do not agree with your

request, we will discuss our decision with you directly if at all possible.

5. Right to Confidential Communication by Alternative Means and at Alternative Locations

- You will be given option on the medical information form to specify how, where and when you may wish to be contacted and what restrictions you might require in the method of contact. (For example, you may not want a family member to know that you are receiving services at RSM PT/Asclepeion Center. On your request we will send your bills to another address). We will honor any reasonable request. You do not need to give us a reason for your request.

- You may also choose whether you wish to be contacted for public information and awareness, resource development and/or research activities.

OUR RESPONSIBILITIES:

It has always been the policy of RSM PT/Asclepeion Center to maintain and protect the privacy of all individuals served to the extent possible.

1. It is our policy to limit disclosures of and requests for Protected Health Information for payment and health care operations to the minimum necessary.

2. We limit which members of our workforce may have access to protected health information for treatment, payment and health care operations, based on those who need access to the information to perform their job functions.

3. All medical records/protected health information are kept in secure locations and only those employees or clinicians who need access to those records for treatment, payment or healthcare operations, have access to the medical records unless you sign an authorization.

4. It is our responsibility and intent to abide by the terms outlined in this notice with respect to the information we collect and maintain. Over time, we may change this Notice of Privacy Practices. If we make changes, we will post the updated version in our office and attempt to provide you with an updated copy.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have any questions and would like additional information regarding the practices of RSM PT/Asclepeion Center for Body Mind Therapy, you may contact Martha Bramhall at 301-495-0933. If after talking to her you still believe your privacy rights have been violated, you can file a complaint with the Secretary of the U.S. Department of Health and Human Services. Under federal law, an individual must file a complaint within 180 days of knowledge or perceived knowledge that the act or omission occurred.

There will be no retaliation for filing a complaint.