Hesch Institute
Jerry Hesch, MHS, PT, DPT(s)

1609 Silver Slipper Avenue
Las Vegas, Nevada 89002
(702) 558-6011 hm/office 9am-6pm PST
(702) 565-6027 fax

www.HeschInstitute.com
email: HeschInstitute@yahoo.com
(702) 561-0143 cell

To future Local Vegas Hesch Institute Patients:

Thank you for choosing the Hesch Institute to help improve your physical health and improve your outlook on life. When visiting the Hesch Institute you will receive a face-to-face experience with Jerry Hesch, MHS, PT, DPT(s), not with a triage nurse or Therapy Assistant. You will receive a full body evaluation by Jerry himself, and your treatment and education will be performed by him alone. It is very probable that this will be the most thorough hands-on evaluation you have ever had.

You have most likely already had a brief (10 minute) phone call with Jerry to discuss the possibility of treatment. If not, you should schedule one to determine if Jerry can help with your situation. This initial phone call is free. Once you complete this New Patient Packet and return it, along with your images and medical reports, Jerry will review everything for a $50 Chart Review fee*, followed by a brief (10 minute) phone consultation to discuss your situation and schedule your appointment.

The cost of the Whole Body Evaluation is $125 and the amount of time it takes is individual for each client. After the initial evaluation, all treatment is billed at $125 per hour, pro-rated.

You should then expect to spend a minimum of 90 minutes up to 2 hours in each of three appointments with Jerry. Your first visit will include the Whole Body Evaluation, followed by treatment. This will most likely be your longest visit. Subsequent visits can be 1 hour to 90 minutes. Every person is different and requires different types and levels of treatment. For some chronic cases Jerry may need to spend some additional time to correct issues.

Treating the whole body is far more effective than simply treating where it hurts. Research supports this approach in down-training the nervous system which continuously records and reports dysfunctions throughout the body and ultimately increases the experience of pain. This research-based approach is named regional inter-dependence.

Once again, thank you for choosing the Hesch Institute. We look forward to helping you in your quest for physical health.

*Some files are extensive and may require additional billable time at the rate of $25 per 15-minute unit.
**It is very rare that the 3 visits exceeds $800 total. 9 out of 10 patients do not pay more than $800 total.

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PATIENT CONTACT INFORMATION

NAME: ____

IF APPLICABLE, NAME OF PARENT OR GUARDIAN:

____

ADDRESS: ____

____

____

PHONE NUMBERS (PLEASE INDICATE WHICH IS BEST TO CALL):

HOME: ____

CELL: ____

WORK: ____

EMAIL: ____

BEST DAY/TIME TO CALL: ____

We do not share your personal information. Refer to document titled Patient Consent and Privacy (HIPPA) Policy.

Hesch Institute
HEALTH HISTORY (Confidential)

Name____________________ Today's Date__________

Age______ Birthdate__________ Date of last physical examination__________

What is your reason for visit?____________________

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period__________

Date of last Pap Smear__________

Have you had a mammogram?__________

Are you pregnant?__________

Number of children__________

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

Pharmacy Name____________________ Phone__________

ALLERGIES To medications or substances

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates.______________________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Signature ______________________________ Date

______________________________ Reviewed By ______________________________ Date

Hesch Institute
PATIENT NARRATIVE

Please complete and attach a brief narrative about your condition. You do not have to repeat information already mentioned on the Health History. You can be brief, however, please go into detail wherever you feel it is helpful.

Include any and all pertinent information, such as:

- ☐ Prior Medical History, please elaborate on anything you feel is relevant.
- ☐ Description of onset, and any event you associate with onset, such as traumas, surgery, childbirth, working conditions, etc.
- ☐ Description of your symptoms, past and current, and any changes.
- ☐ What makes your symptoms worse, what helps.
- ☐ Treatments you have tried (including medications), and the outcome (from traditional AND non-traditional practitioners).
- ☐ Tests you have undergone, including x-ray, MRI, CT, etc.
- ☐ Specialists you have seen for consultation.
- ☐ Specialists you have seen for treatment.
- ☐ Please list in chronological order any specialists you have seen.
- ☐ Explain why you believe it has not resolved.
- ☐ Explain what you feel is needed and what you hope to accomplish.
- ☐ Any other information you believe might be significant.

Please attach copies of imaging reports if you have them. If possible, Mr. Hesch also prefers to see images, which can be sent via email, mail or bring the films with you.

Please use additional pages as necessary

Hesch Institute
PAIN DRAWING

NAME____ DATE:_______________

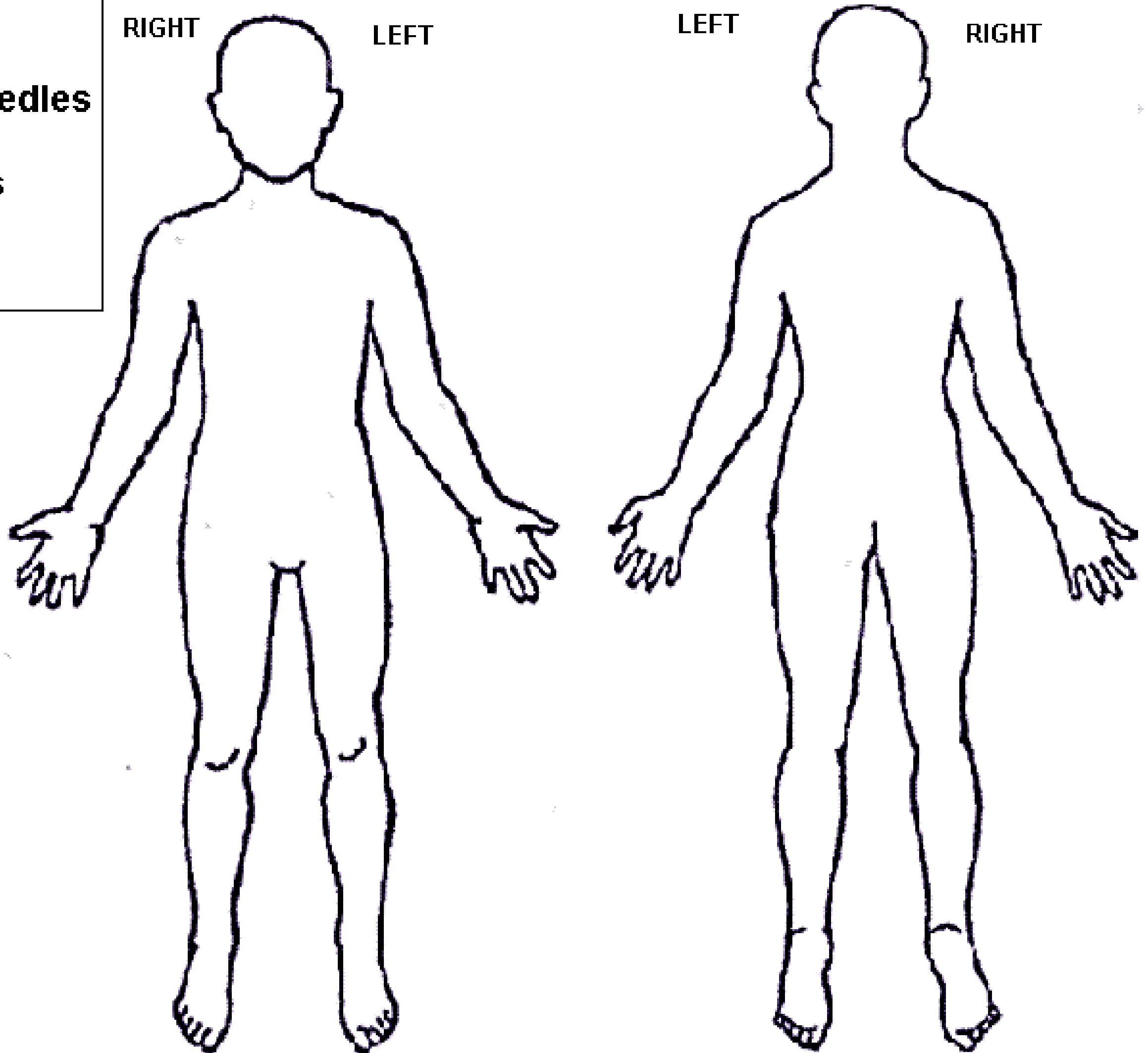
Instructions: Mark these drawings according to where you hurt. Please indicate the sensations you feel by referring to the key below.

KEY

- //////////// Stabbing
- XXXXX Burning
- OOOO Pins & Needles
- ===== Numbness
- +++++ Aching

ARE YOU:

☐ RIGHT HANDED ☐ LEFT HANDED



PAIN LEVEL KEY

0 NO PAIN

1 MILD PAIN - YOU ARE AWARE OF IT BUT IT DOESN'T BOTHER YOU

2 MODERATE PAIN THAT YOU CAN TOLERATE WITHOUT MEDICATION

3 MODERATE PAIN THAT REQUIRES MEDICATION TO TOLERATE

4-5 MORE SEVERE PAIN; YOU BEGIN TO FEEL ANTISOCIAL

6 SEVERE PAIN

7-9 INTENSELY SEVERE PAIN

10. MOST SEVERE PAIN; IT MAY MAKE YOU CONTEMPLATE SUICIDE

CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

Hesch Institute
INFORMED CONSENT AND PERMISSION TO TREAT

I authorize permission to be treated by the Therapist(s) at Hesch Seminars and Physical Therapy, LLC, of Henderson and Las Vegas, Nevada. All treatments, including manual therapy techniques, will comply with state and federal guidelines. Jerry Hesch, MHS, PT is licensed in Nevada to practice Physical Therapy, Nevada License #1789.

We comply with the APTA (American Physical Therapy Association) Physical Therapy Practice Code of Ethics. The State of Nevada entitles a Physical Therapist Direct Access within specific guidelines. Direct Access allows a licensed Physical Therapist to evaluate and treat a patient without the need for a Physician's referral or script. However, in the course of the evaluation, should the Therapist discern that the patient requires treatment for a serious medical condition not previously assessed by a practitioner of record, the Therapist will recommend medical follow up.

I understand that I am an active participant in my therapy, and it is my responsibility to provide accurate and timely feedback to the Therapist regarding my response to any technique or exercise. It is my responsibility to keep my Therapist updated on any change(s) in my healthcare status, such as car accident, new injury, change in symptoms, medication, etc. I also agree to immediately inform my Therapist if I am experiencing during the course of treatment any new sensation, any enhancement of existing abnormal sensation, any new symptoms, or any increase in existing symptoms. For example I shall immediately inform the Therapist if I am experiencing increased pain, burning, tingling, numbness, dizziness, nausea, etc.

As a Patient, I understand that I am in full control of my treatment and I have the right to halt any technique or exercise at any time by telling my Therapist to stop. The Therapist will comply with this request immediately.

As a patient I have the right to receive information regarding my care and can ask questions anytime. Information can include but is not limited to:

- the planned examination/assessment
- the evaluation, diagnosis, and prognosis/plan
- the intervention/treatment to be provided
- the risks which may be associated with the intervention
- the expected benefits of the intervention
- the anticipated time frames
- the anticipated costs
- any reasonable alternatives to the recommended intervention

PERMISSION TO TREAT cont.

I understand that small gentle forces which are named spring tests will be applied throughout my body and that if these are uncomfortable they can be stopped immediately and performed more slowly and with less force, or discontinued. I understand that sometimes soreness can result from hands-on treatment and from exercise, and it is extremely rare for patients to experience an increase in pain in response to the gentle treatment provided by Hesch Institute. I understand that Mr. Hesch and/or any other clinician is constantly vigilant in reading the response of my body to intervention, in an effort to provide safe and effective care.

By signing below, I acknowledge that I have read, understood, and will comply with the above; and I authorize permission to treat.

Patient Name (Please Print)

Patient Signature Date

Therapist Signature Date

Hesch Institute
PATIENT PRIVACY (HIPAA) POLICY

I understand there is a copy of the federally mandated Notice of Privacy Practices, available for me to read. This HIPAA Privacy Notice describes the Practice's obligation to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use my health information for treatment, payment, and health care operations. I know that I have a right to review the Practice's HIPAA Privacy Notice and ask for clarification of the document. I understand the Practice is required to maintain the privacy of my health information in accordance with the terms of the federally mandated HIPAA Privacy Notice.

I understand that I may, upon request, obtain a printed copy of the Practice's HIPAA Privacy Notice.

I understand that my health care records will not be shared or discussed except as I specifically designate on the separate form entitled "Authorization to Disclose Health Information". If I want my health information to be communicated to other Practitioners, or to any other party such as a relative, I shall designate any such Practice or individual on the Authorization form.

I understand that if I provide insurance billing information to the Practice, and sign to request that my insurance be billed for any care I receive, information from my health care records may be disclosed to my insurance company if my insurance company requires this to process reimbursement.

____ ____________________

Signature of Patient or Patient's Representative Date

If this consent is signed by a Patient's Representative, please complete the following:

Patient's Representative Name (print) ____

Describe Representative's authority to act for Patient ________________________________

____

Hesch Institute
FINANCIAL POLICY

- New Patient Packet and medical records may be mailed to the Home Office address, or attached as a single file to an email and sent to heschinstitute@yahoo.com .
- A $50 Chart Review Consultation fee is required along with submission of the New Patient Packet and all relevant medical records and imaging studies. This fee applies to the time spent reviewing your records and subsequent communications, up to 30 minutes. If additional time is needed, the rate is $35 per each additional 15 minutes.
- A phone consultation without chart review is billed at $50 for up to 20 minutes. If additional time is needed, the rate is $35 per each additional 15 minutes.
- The Initial Chart Review Consultation includes a careful review of all records followed by a telephone and/or email consultation, prior to scheduling an office visit. Prior Chart Review is very helpful for chronic and complicated cases.
- Hesch Institute is an out-of-network provider. If you have out-of-network insurance benefits, at the conclusion of care and upon request, we will provide an invoice with insurance billing codes and amount paid. You may submit this to your insurance for reimbursement of your expenses under the terms of your insurance policy.
- For MVA's and occasional insurance assignment, billing is based on appropriate CPT codes which typically covers a 1-15 minute unit of time. Cash pay is already discounted, whereas MVA and insurance reimbursement is typically discounted by the insurance carrier. We reserve the right to elect to use or not use insurance or MVA liens. If using insurance or MVA liens we bill according to ethical standards in the profession.
- Hesch Method is brief treatment. Out-of-town clients are booked for three office visits on three consecutive days. In-town clients are booked for an initial office visit and then follow-up care as needed, but can expect their overall care to take a similar amount of time. Typically if the condition is chronic and involves more than one body region, the first visit is 2 hours, second is 1½ to 2 hours, and third is 1 to 1½ hour. Simple, acute injuries typically require only a 1 hour visit. This is an average and will vary depending on clinical findings.
- The initial evaluation is a whole body evaluation, and the fee is $150 for up to 90 minutes of in-person on-site evaluation.
- Hesch Institute bills $125 per hour. This is prorated so that you will not pay a full $125 for a period of less than one hour. Hesch Institute bills for all time spent on your care - that is, the hourly rate applies to in-person evaluation, review of records, letters to providers, and telephone and email consultations. Brief visits can be scheduled for follow-up care at $50 for 20 minutes or less. **Please expect a charge for an additional 15 minutes ($35) at your final visit, to cover time routinely spent in follow up communication due to inquiries from your insurance company and health care provider(s)**.

FINANCIAL POLICY cont.

- Although this is specialty care, our fees for services are significantly lower than traditional physical therapy clinics and specialty PT services. Due to our small size, our commitment to one-on-one care without the use of allied care providers (technicians, etc.) our time investment in your care is much greater. The skill set and education can be reviewed online under Jerry's Curriculum Vitae (abbreviated version).
- Payment for all services is due at time of service. We accept cash, US checks*, and credit cards. We can take credit card information by telephone M-F, 9am-5pm PST, at (702) 558-6011. **(*if paying by check please make checks out to Hesch Institute*)**
- Questions about this financial policy may be directed to heschinstitute@yahoo.com .
- Hesch Institute reserves the right to refuse service to anyone if the clinician determines that care is not appropriate, or that a therapeutic relationship is not present.

Signed ____ Date ________________

Print Name____

Hesch Institute
CANCELLATION AND NO SHOW POLICY

The foundation of the Hesch Institute practice is individual, hands-on treatment by Jerry Hesch, MHS, PT, DPT(s). Mr. Hesch sees one patient at a time. There will be no Physical Therapy Assistants or other ancillary staff participating in your care. You will receive one-on-one care for the duration of your visit.

As a result, no-shows or cancellations with less than 24 hours' notice have a significant impact on the Practice. As appointments are generally one hour or more in length, no-shows and late cancellations lead to an hour of idle time in our office.

Patients who no-show, or cancel with less than 24 hours' notice, will be asked to pay a cancellation fee prior to their next appointment. The fee is $50.00 for an hour appointment, or $25.00 for a half hour appointment.

By signing below I agree to compensate Hesch Institute, for any appointment to which I do not show, or cancel with less than 24 hours' notice. Compensation will be $50.00 for an hour appointment; and $25.00 for a half hour appointment.

Signed ____ Date ________________

Print Name____

Hesch Institute

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This form is only to be completed if you want Hesch Institute to share information with someone you choose.

NAME:____ DOB: ________________

I authorize the use or disclosure of the above named individual's health information as described below:

Jerry Hesch, MHS, PT, DPT(s), and Hesch Institute, are authorized to make the disclosure of the following information:

Case records, including (check all that apply):

___________ History and Physical

___________ Summary report of consultation and treatment

___________ Problems list

___________ Discharge summary

___________ Other ____

For the dates of care from ______________________ to ___________________.

This information may be disclosed to and used by the following individual(s) or organization(s). Please list any practitioner(s) or other party whom you wish to receive records. Please provide contact information.

NAME ADDRESS PHONE/FAX

____

____

____

____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Jerry Hesch, MHS, PT, DPT(s). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION cont.

If no expiration date, event, or condition is specified, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. If I have questions about the disclosure of my information, I can contact Jerry Hesch, MHS, PT, DPT(s).

____ ____________________

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

PRINT NAME ____

IF SIGNED BY LEGAL REPRESENTATIVE, AUTHORITY TO ACT FOR PATIENT:

____

____ ____________________

SIGNATURE OF WITNESS DATE

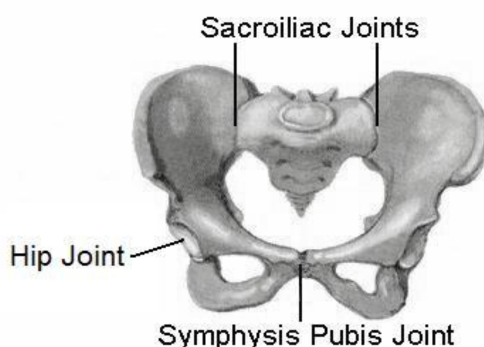
Hesch Institute

PATIENT CONSENT TO PELVIC LANDMARK HIP AND THIGH BONE EVALUATION

You are scheduled to receive a Manual Therapy exam conducted by Jerry Hesch, MHS, PT, DPT(s), developer of the Hesch Method of Manual Therapy and Hesch Springing with Awareness™, a unique and highly effective method to assess the joints of the body.

While the Hesch Method is a whole body approach, Mr. Hesch has developed a particularly noteworthy body of work in regards to the pelvic, hip and thigh bone joints. The pelvis, hip and thigh bones are in many ways the center of the skeletal system, and proper joint function within the pelvis, hip and thigh bones is essential to fluidity of movement throughout the entire body. A joint problem in the pelvis, hip or thigh bones can create additional joint problems for some individuals, in areas even as distant as the feet, head, neck and TMJ. Therefore, a complete and accurate Hesch Method screening of the pelvis, hip and thigh bones is essential if Mr. Hesch is to provide you the highest quality of care.

Here is a picture of the pelvic joints:



One key joint in the pelvis, the symphysis pubis, is located in the pubic area. To examine you properly, Mr. Hesch will need to briefly palpate the position of the bony pelvis and test motion by pushing on the pelvic joints, including the symphysis pubis joint and surrounding pubic bones, the ligaments and muscles. This is an external exam and you shall remain fully clothed while this area is palpated. The private areas are not evaluated, only the joints, ligaments and muscles. We wish you to have a full understanding before the exam, that the exam includes the upper pubic joint area, as well as the buttocks, hips and low back. This is an essential element to complete and accurate Hesch Method examination.

PLEASE INITIAL ONE OF THE LINES BELOW:

_____ I understand that my exam may include palpation of my symphysis pubis joint, pubic bones, and other pelvic structures including the fibrocartilage, ligaments and muscles in the pelvis, buttocks, hips and low back. I am comfortable that this exam is for my medical benefit, and I provide my informed consent.

_____ I am uncomfortable receiving an exam as described above, by a male practitioner, unless a female employee, or my own friend or relative, remains in the room during this portion of the exam. I understand that while the staff will do their best to accommodate this request, it is not standard policy as the exam is not internal. Therefore, if I require a staff member to be present and none is available, I might have to reschedule my appointment.

_____ I do not consent to be examined in the pelvic area. I understand that, if my symptoms or findings suggest to Mr. Hesch that such an exam would be necessary to provide proper and effective care for my condition, he may refuse to treat me, and refer me to another practitioner.

SIGNATURE: ____

PLEASE PRINT NAME ____