Hesch Institute

Dr. Jerry Hesch, PT, MHS, PT,

25837 E. Maple Place
Aurora, Colorado 80018
Phone: (303) 366-9445 8am-5pm MST

www.HeschInstitute.com
Email: info@HeschInstitute.com
FAX: (303) 366-9998

To Colorado Hesch Institute Patients:

Thank you for choosing the Hesch Institute to help improve your physical health and well-being. When visiting the Hesch Institute you will receive one-on-one care with Jerry Hesch, DPT, MHS, PT as Dr. Hesch does not utilize therapy assistants or technicians.

Dr. Hesch and his wife Karin have a home office in Aurora, Colorado. In addition to providing patient care, Jerry and Karin present continuing education seminars to hands-on clinicians, and are active in conference presentation, research and publication.

Local clients are scheduled for one-hour visit per day. Most conditions require a minimum of three days. The first visit includes reviewing your medical history, a comprehensive full body evaluation, and treatment billed at $200.00. Each additional day's visit will be $150.00. Estimated total for the 3 days will be $500.00.

If additional time is needed, per mutual agreement, additional time will be billed in 15 minute increments of $36.00.

Please bring comfortable clothing such as athletic wear. Please bring any devices you use for self-care to include foot orthotics, supports or braces, etc.

Once again, thank you for choosing the Hesch Institute. We look forward to participating in your health care.

Sincerely Yours,
Dr. Jerry Hesch, MHS, DPT, PT
Hesch institute

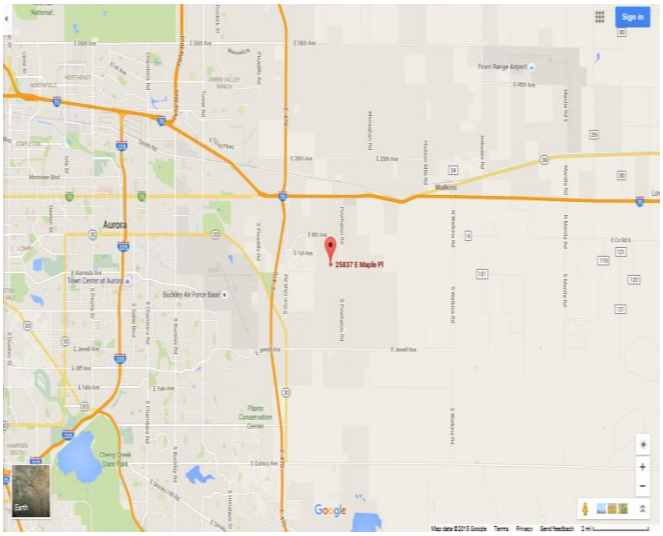
Local Map to Home Office
Dr. Jerry Hesch, DPT, MHS, PT
Hesch Institute
25837 E Maple PL
Aurora, CO 80018

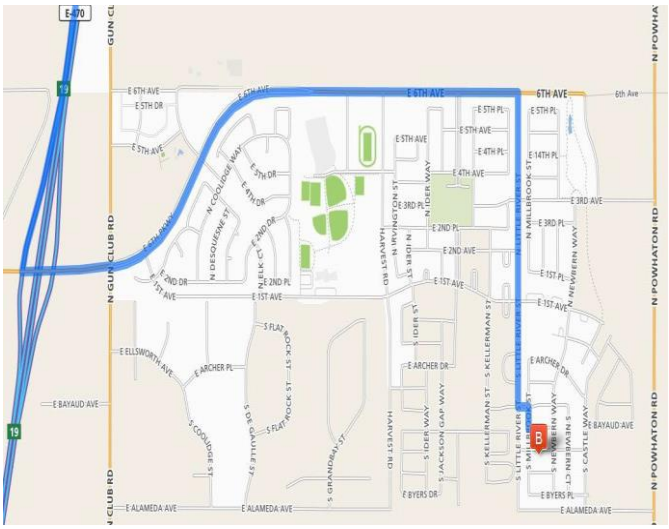
<u>When using a GPS please utilize the cross streets:</u>
<u>E. Maple PL and S. Millbrook St.</u>

This will take you to the street intersection which is two houses away.
At present, several map functions default to the wrong zip code when using the exact street address.

DRIVING DIRECTIONS FROM E-470 and E 6th Parkway

1. Star from Interstate E-70 and E-470
2. Merge onto E-470 (Portions toll).
3. Take EXIT 19 toward E 6th Parkway.
4. Turn left onto E 6th Pkwy.
5. E 6th Pkwy becomes E 6th Ave.
6. Turn right onto N Little River St.
7. N Little River St becomes S Little River St.
8. Turn left onto E Bayaud Ave.
9. Turn right onto S Millbrook St.
10. Turn left onto E Maple Dr.
11. 2nd house on left is 25837 E Maple PL





Hesch Institute
Dr. Jerry Hesch, DPT, MHS, PT

25837 E. Maple Place
Aurora, Colorado 80018
Phone: (303) 366-9445 8:00am-5:00pm MST

www.HeschInstitute.com
email: info@HeschInstitute.com
Fax (303) 366-9998

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. Please 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

INSTRUCTIONS FOR 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.

The New Patient Packet and medical records may be mailed to the Home Office address (see above), or attached as a *single* PDF or WORD file to an email and sent to info@heschinstitute.com.

Please include any and all pertinent information, such as:

- Brief Overview of Medical History (please include all, even if seems to be unrelated)
- Description of onset
- Description of your symptoms, past and current.
- 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. Please attach test reports and bring original films or films on CD if available.
- Please briefly list all health care practitioners you have seen for consultation and treatment.
- Please explain what you hope to accomplish.
- Any other information you believe might be significant.

Hesch Institute
PAIN DRAWING

Name: _____

Date: _____

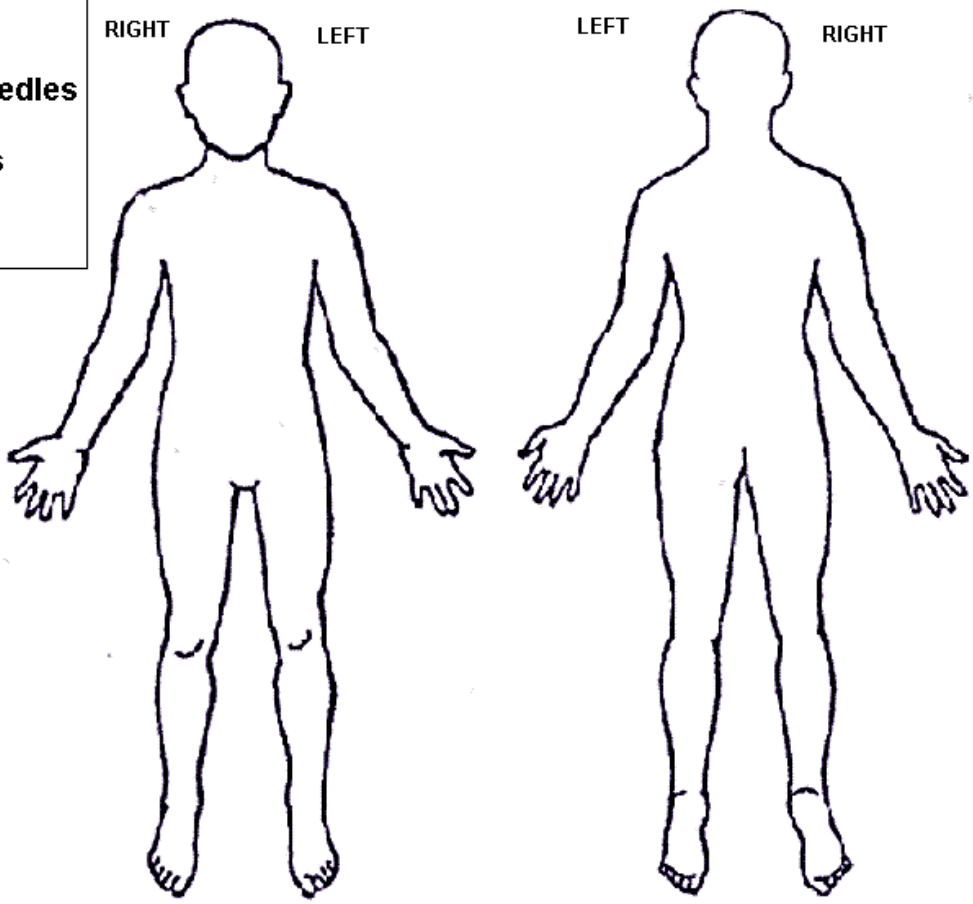
Instructions: Mark these drawings according to where you hurt. Please indicate the sensations you feel by referring to the key below.

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 Dr. Jerry Hesch, DPT, MHS, PT, of the Hesch Institute, of Aurora and Denver, Colorado. All treatments, including manual therapy techniques, will comply with state and federal guidelines. Jerry Hesch, DPT, MHS, PT, is licensed in the state of Colorado to practice Physical Therapy, Colorado License # 00012320.

We comply with the APTA (American Physical Therapy Association), the Colorado State Physical Therapy Association, the American Academy of Orthopedic Manual Physical Therapy and the International Federation of Manual Physical Therapists, Code of Ethics, and the Physical Therapy Practice Act. The State of Colorado 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 medical referral or additional diagnostic tests, Dr. Hesch 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 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

I understand that very small gentle measured forces which are named spring tests/force-transmission tests will be applied to joints throughout my body. Treatment is similar, using gentle forces applied for a few minutes to coax the body's cooperation, rather than impart abrupt forces as is common practice with joint-focused therapies. However, if any portion of the evaluation and treatment should be uncomfortable, or cause new symptoms or increase in existing symptoms such as soreness, pain, numbness, tingling, temperature changes, etc., I am to report them immediately and the procedure will be stopped and interpreted and modified appropriately. Again, this is a very gentle method, and it should not provoke symptoms. Some injuries are highly sensitized and there is less than a 5% chance of symptoms being worse in response to treatment. You are in control of your care, and this applies to any exercise or self-treatment in the clinic or at home. You can always decline treatment if you are uncomfortable with it or have concerns. I understand that on rare occasions 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 Dr. 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

Hesch Institute

PATIENT PRIVACY (HIPAA) POLICY

I understand there is a copy of the federally mandated Notice of Privacy Practices, is 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:

(Print) Patient's Representative Name: _____

Describe Representative's authority to act for Patient_____

_____

Hesch Institute

FINANCIAL POLICY

For Colorado clients: In-town clients are booked for an initial office visit and then follow-up care as needed, which typically take at least three total visits of one-hour each. A one-hour visit is billed at $125.00. For complex presentations additional time or additional number of visits are available. Additional time is billed at $31.25 per 15-minute unit.

- 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 (assistants, technicians, etc.) our time investment in your care is much greater. Dr. Hesch's education can be reviewed online under Jerry's Curriculum Vitae.
- The hourly rate applies to in-person evaluation, treatment, review of records, letters to providers, and telephone and email consultations.
- 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, 8am-5pm PST, at (303) 366-9445 (*if paying by check please make checks out to Hesch Institute).
- At the conclusion of care, 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 one 15-minute unit of time. We reserve the right to not use insurance or MVA liens.
- 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 _____

CANCELLATION AND NO SHOW POLICY

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

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.

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.

Signed _____ Date_____

Print Name _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Hesch Institute

25837 E Maple Pl, Aurora, Colorado 80018

Fax - 303-366-9998/Phone - 303-366-9445

This form is optional. It's 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:

Dr. Jerry Hesch, DPT, MHS, PT, and Hesch Institute, are authorized to make the disclosure of the following information: Case records, including (check all that apply):

_____ History and Physical
_____ Treatment Record
_____ Discharge summary or letter
_____ 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, TITLE 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 Dr. Jerry Hesch, DPT, MHS, PT of the Hesch Institute. 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:

If no expiration date, event, or condition is specified, this authorization will expire in 5 years.

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, DPT, MHS, PT or Hesch Institute.

_____ _____
SIGNATURE OF PATIENT DATE

PRINT NAME _____

IF SIGNED BY LEGAL REPRESENTATIVE, AUTHORITY TO ACT FOR PATIENT

_____ _____
SIGNATURE OF LEGAL REPRESENTATIVE DATE

_____ _____
SIGNATURE OF WITNESS DATE