OUT-OF-TOWN PATIENT PAPERWORK PART 2

Please thoroughly fill out and send these pages.

Patient Contact Information

Name: ____

Street: ____

City: ____

State: ____

Zip Code: ____

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 documenttitled Patient Consent and Privacy (HIPPA) Policy.

HEALTH HISTORY

Please briefly describe your medical history. There is additional space on the next page.

Name ____Date: _______________________

Date of Birth: ___________________________________ Age: ______________________

Occupation: ___________________________________

If retired, please state prior occupation: ____

Diagnosis: ____

Reason For visit: ____

____

What do you think is the cause of your symptoms? _______________________________

____

____

____

What do you think you need to get better? _______________________________________

____

____

____

When was your last physical? ____

Report any general symptoms you may have.

- o Depression
- o Dizziness
- o Headache
- o Loss of sleep
- o Loss of weight

Current medications: ____
____
____
____
____
____

Continued)

Hospitalizations:
____
____
____

Surgeries: ____
____
____

Injuries: ____
____
____

Serious Illnesses:
____
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____

Please describe any major illness in parents or siblings: ______________________
____
____

Is there anything else I should know?
____

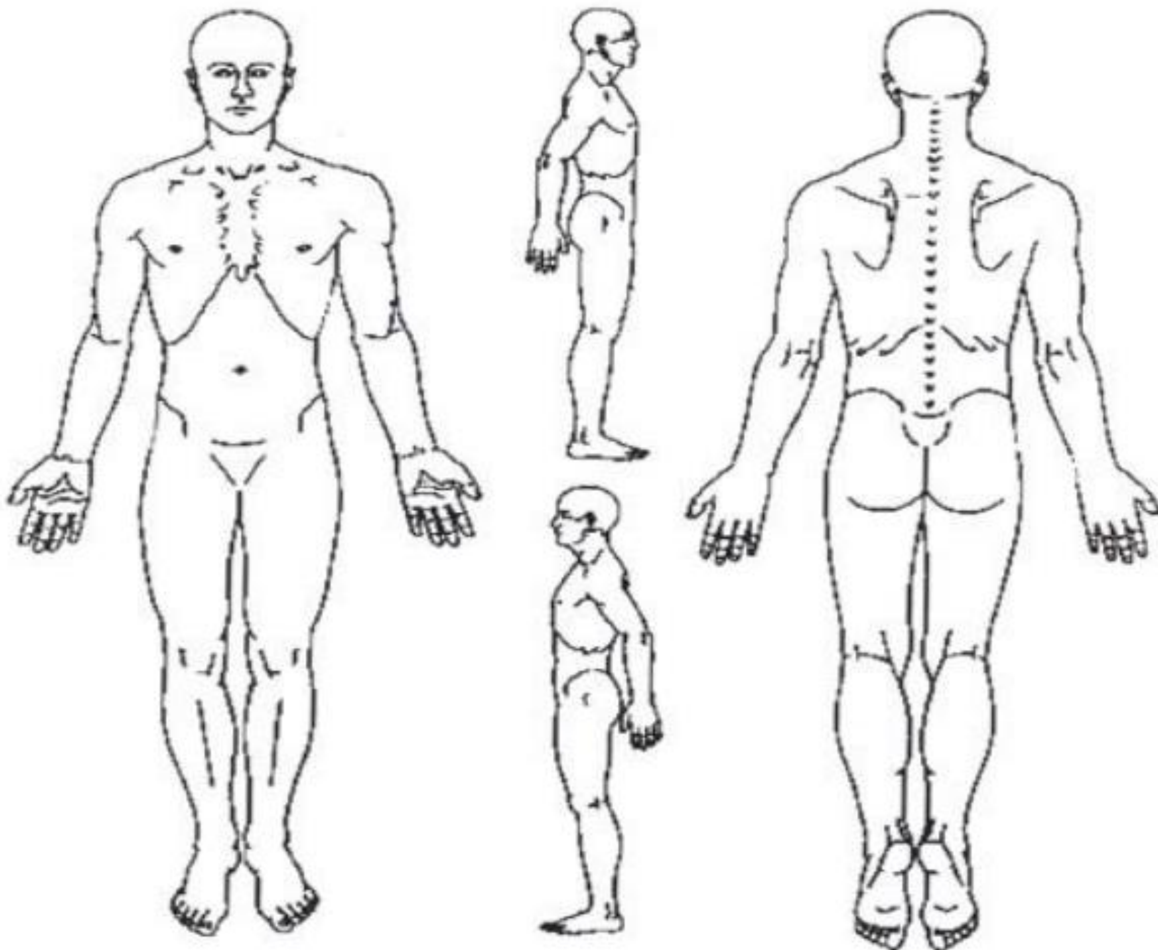
For women:

1. When was your last Gynecologic visit, including PAP smear?
   ____
2. Please describe pregnancy history:
   ____

PAIN DRAWING

Instructions: If you are using the online PDF filler, depending on which Adobe products you have, you might not be able to fill this out online. ***If not, please print this page and fill it out everywhere that you have symptoms.*** On your first visit, you can elaborate on the type of sensation. While pain can vary from day to day, the idea is to provide a general representation of how you have felt over the past week. Please also include any areas where you experience movement impairment, even if not painful. ***Please scan as a PDF and send as an Email attachment, or FAX to 1-303-366-9998, or send via US Mail.***

Please provide a numerical pain rating using a 1-10 Pain Scale for each region. It should represent the average pain, with an arrow pointing to the body region. Contact Jerry Hesch if you have any questions.



From https://www .cfprc.com/pain-diagram.html (no spaces)

INSTRUCTIONS FOR PATIENT NARRATIVE

Please complete and attach a brief narrative about your condition. You do not have to repeat information already mentioned in the Health History. You can be short; however, please provide details wherever you feel it is helpful.

The New Patient Packet and medical records may be mailed to the home office address (Hesch Institute, 25837 E Maple Pl, Aurora, Colorado, USA 80018) or attached as a single PDF or Word file to an email and sent to info@heschinstitute. com (no spaces)

Please include all pertinent information and *place a checkmark when complete:*

_____ Brief Overview of Medical History (please include all, even if it seems to be unrelated)

_____ Description of onset

_____ Description of your symptoms, past and current.

_____ What makes your symptoms worse, and 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 the original films or copies on CD, if available.

_____ Please briefly list all health care practitioners you have seen for.

_____ Consultation and treatment.

_____ What do you think is the cause of your pain?

_____ What do you think you need to get better?

_____ Please explain what you hope to accomplish.

_____ Any other information you believe might be significant?

If you need additional space, use the next page, or use a Word document or any other method.

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FINANCIAL POLICY FOR OUT-OF-TOWN CLIENTS

Clients begin with an initial office visit that includes a comprehensive whole-body evaluation and treatment. During the next two, you will be reevaluated and receive hands-on therapy as needed. You will also learn a personalized exercise program, along with ideal body mechanics and ergonomic principles.

The goals are to:

- Help you become as independent of healthcare providers as possible
- Significantly reduce your out-of-pocket expenses
- Help you move confidently and manage your mobility independently

For most presentations, three visits are scheduled. For simple diagnoses involving a single body part (e.g., coccyx pain, wrist pain), two visits are often sufficient. Our goal is to reduce pain and support your long-term mobility and well-being.

His education can be reviewed online here: https://www.heschinstitute.com/qualifications.html

FEES:

This is a fee-based specialty service, billed at:

- Day 1. The fee is $350.00 on Day 1 for up to a 2-hour whole-body evaluation and treatment.
- Day 2 is $300.00 for up to 2 hours.
- Day 3 is $300.00 for up to 2 hours.
- If additional time is required, the fee is billed at $37.50 per 15-minute increment.

You may schedule up to 2 follow-up phone or video calls, each lasting 15 minutes. If you wish to have Jerry critique your performance of the self-treatment taught or the exercises. Additional time is billed at $37.50 per 15-minute increment. This also applies to email or text communication.

On occasions, especially for simple presentations, only two visits are needed. Fees are clearly explained before your first visit. Please contact Hesch Institute for any questions.

The fees also apply to history-taking, record review, letters to providers, telephone, and email communication. Payment for all services is due at the time of service. We accept cash, US checks, * and credit cards (*if paying by check, pleasemake checks out to Hesch Institute). We also accept Flexible Spending Account, Health Savings Account, and other similar cards.

Due to our small size and our commitment to one-on-one care without the use of allied

care providers (assistants, technicians, etc.), our time investment in your care is significantly greater than traditional models. He and no one else thoroughly evaluates you. As the Hesch Method is a unique form of care, we do not offer cookie-cutter care.

By Sunday p.m. in the week following your visit, you will receive a complete, coded receipt suitable for submission to your insurance. Hesch Institute charges a flat fee for each visit; the care is not based on time or services. The units listed on the receipt match the units noted in the note and are defensible.

Within 10 days of your final visit, you will receive a complete, coded receipt suitable for submission to your insurance provider. The Hesch Institute charges a flat fee for each visit; care is not based on time or individual services, except for time that exceeds the scheduled visit (If additional time is required for any visit, it is billed at $37.50 per 15-minute increment). The units listed on the receipt correspond to those documented in your clinical note and are entirely defensible.

- Please consult your insurance provider with any questions.
- The Hesch Institute is not in network with any insurance provider, as we are a cash-based practice.
- Some insurance companies may reimburse a portion of the submitted claim, while others may not.
- The amount you pay should still apply toward your annual deductible.
- If, after reviewing your paperwork, Dr. Hesch determines that you may benefit from additional imaging or a specialty consultation (e.g., rheumatology, pain management), he will make that recommendation.
- The Hesch Institute reserves the right to refuse service if the clinician determines that care is not appropriate or that a therapeutic relationship cannot be established.
- Please contact the Hesch Institute with any further questions.

Signed

Date

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 ancillary staff participating in your care. You will receive one-on-one care throughout your entire visit.

Patients who don't show or cancel with less than 24 hours' notice will be asked to pay a cancellation fee beforetheir next appointment. The cost 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: ______________________________

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, the International Federation of Manual Physical Therapists, the Code of Ethics, and the Physical Therapy Practice Act. The State of Colorado entitles a Physical Therapist to 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, during the evaluation, if the Therapist determines that the patient requires a medical referral or additional diagnostic tests, Dr. Hesch will recommend the appropriate course of action.

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 treatment any new sensation, any enhancement of existing abnormal sensation, any new symptoms, orany 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 complete 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.

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 an 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, interpreted, and modified appropriately.

Again, this is a very gentle method, and it should not cause symptoms. Some injuries are highly sensitive, and there is less than a 5% chance of symptoms worsening 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 exercise. It is also rare for patients to experience an increase in pain in response to the gentle treatment provided by the Hesch Institute. I understand that Dr. Hesch and/or any other clinician is constantly vigilant in reading the reaction of my body to intervention, to provide safe and effective care.

As a patient, I have the right to receive information about my care and can ask questions at any time regarding the following, and anything else:

- Information can include, but is not limited to, the evaluation, physical therapy diagnosis, prognosis, and plan.
- The interventions/treatments to be provided
- Any risks exceeding 3% associated with the intervention
- The expected benefit of the intervention
- The anticipated time frames
- The anticipated costs
- Any reasonable alternatives to the recommended interventions

Signature of Patient: ________________________________ Date: ________________________

Name of Patient (print): ____

If a Patient's Representative signs this consent, please complete the following:

Signature of Patient's Representative: ____

Date: ____________________________

Patient's Representative Name (Print)____

Describe Representative's authority to act for patient: _________________________________
____
____
____

HIPPA/ The Health Insurance Portability and Accountability Act*

I understand that a larger document, titled **Notice of Privacy Practices,** is available in the Patient Section, which I can download and print. It is also located on the bulletin board in the treatment room at Hesch Institute.

I understand that a copy of the federally mandated **Notice of Privacy Practices (Notice)** is available in the Patient Tab on the Hesch Institute website. It is available to download and print. It is also located in the Hesch Institute treatment room on the bulletin board. This page is an abbreviated form of that document. This HIPAA abbreviation describes the Practice's obligation to ensure the privacy of my health information. The Notice also explains how the practice may use my health information for treatment, payment, and health care operations. I know thatI have a right to review the Practice's **Notice of Privacy Practices** and ask for clarification of the document. I understand that Practice is required to maintain the privacy of my health informationbythe 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 know that my health care records will not be shared or discussed except as I specificallydesignate on the separate form entitled "Authorization to Disclose Health Information". Suppose I wantmy health information to be communicated to other Practitioners or any other party, such as a relative. In that case, I shall designate any such practitioner or individual on the Authorization form.

Signature of Patient: ______________________________ Date: ___________________

Name of Patient (print): ____

If a Patient's Representative signs this consent, please complete the following:

Signature of Patient's Representative: ____________________________

Date: _________________________

Patient's Representative Name (Print):
____

Describe Representative's authority to act for the patient: ___________________________
____

*From: https://www. ncbi.nlm.nih.gov/books/NBK500019/ (no spaces)

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 HeschInstitute to share information with someone you choose.

Dr. Hesch can provide you with a letter summary of your presentation and treatment on request.

Print Name:

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 (Explain) ____

For the dates of care from: ____

Until: ____

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

NAME, TITLE ADDRESS PHONE/FAX

____

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I understand that I have the right to revoke this authorization at any time. I know 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 know that the revocation will not apply to my insurance company if the law allows my insurer 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 may inspect or copy the information to be used or disclosed. If I have questions about the disclosure ofmy information, I can contact Jerry Hesch, DPT, MHS, PT, or Hesch Institute.

Signature Of Patient: ______________________________ Date: ____________

Print Name: ____

If signed by a legal representative, the authority to act for the patient:

Signature Of Legal Representative: ______________________________

Date: ______________________________

Signature Of Witness: ____

Date: ______________________________