Welcome to the Pain Relief Center.

Our goal is to help you achieve as pain-free state as possible. Your first visit will last approximately 40-50 minutes where a complete evaluation will be performed. **Please note: You will need to have a current prescription for physical therapy from a physician, dentist, or podiatrist prior to your first visit.** I will be happy to assist you in obtaining a prescription from your doctor. Frequency of treatment will be determined at your evaluation session with input from your physician as well.

At the present time, we are In-Network Providers with most Excellus and most Blue Cross/Blue Shield plans, Aetna, and Independent Health insurance plans, with co-payments expected at the time of service. **I am no longer accepting Medicare or No-Fault (Motor vehicle)**. If you have a Medicare plan as your primary insurance I will not be able to see you for treatment, for Medicare regulations prohibit me from seeing you as an Out-of-Network patient, even if that is your wish/and wish to pay privately. Otherwise, Out-of-Network physical therapy sessions are $120 for a standard 50-minute session, $180 for a 75-minute session, $240 for an extended 100-minute session, and $60 for a 25-minute session. Payment in the form of check, cash, or credit card is required at the time of each visit. We also accept HSA and Flexible Spending Account cards. Initial evaluations for cash/Out-of-Network patients are $120 (pediatric evaluations are $60.00).

Out-of Network Coverage for Physical Therapy: For patients who's health insurance we do not accept, if your health insurance allows you to submit bills to them for reimbursement or allow you to see an out of network physical therapist, you may receive reimbursement for our fees. We will provide you with the necessary documentation in the form of receipts and progress notes to assist you in receiving reimbursement from your health insurance company. Due to the complex nature of insurance claims and reimbursement, we make no promises as to whether you will receive reimbursement. We recommend that you call your health insurer and ask if you have coverage for ***"Out of Network Physical Therapy".*** They should reply with either a "yes" or "no". If yes, ask what the coverage entails. A typical response would be "You have a $250 deductable and then you are covered for 75% of expenses after the deductable is met". If in doubt, please contact us for more questions regarding your specific insurance.

PLEASE NOTE:
Since therapy at the Pain Relief Center is hands-on in nature, we 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 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. If you have specific concerns in this area, do not hesitate to let us know.

We ask that you not wear any body lotion or oils on the day of your evaluation or subsequent sessions.

An appointment is a commitment to our work and a contract between us. On rare occasions, we may not be able to start on time. This is usually because a treatment is taking slightly longer than expected. For this we 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 so that I can attempt to fill the vacant appointment. **A 24-hour notice is required for cancellations to avoid payment of a $50 fee.**

We are dedicated to providing you with the best possible care at the Pain Relief Center. We welcome your suggestions and are pleased to have the opportunity to be of service to you.

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

I, _____, acknowledge that I have received and understand the **NOTICE OF PRIVACY PRACTICES** from Walt Fritz, PT and the Pain Relief Center, 980 Westfall Rd, Suite 105, Rochester, NY 14618 on _____.

I give permission for Walt Fritz, PT/Pain Relief Center to communicate with the people listed below. Permission may be revoked at any time by contacting us at 585-244-6180.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

_____
(Patient Signature)

HISTORY FORM
Please Bring This Form with You on Your First Visit

Name: _____

Address: _____

Town: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Work: _____ Cell: _____

Today's Date: _____ Date of Birth: _____ Physician's Name: _____

Date of Last MD Visit: _____ Next MD appointment?_____ Occupation:_____

Are You Currently Working? _____ Hours worked per week: _____

How Did You Hear About the Pain Relief Center? _____

Your email address is requested for email notification of upcoming appointments. Also, you may opt-in to receiving the monthly Pain Relief Center Newsletter.

Email address: _____

(Please Check) I agree to allow Walt Fritz, PT to contact me for notification of upcoming scheduled appointments or routine correspondence: _____ Yes _____ No

I wish to receive monthly email Newsletters and Updates on the Pain Relief Center:
_____ Yes _____ No

Health Insurance Company and full policy number:
_____

Name of primary member of health insurance, their relationship to you, and their date of birth:

_____

THE FOLLOWING IS VERY IMPORTANT IN OUR EVALUATION PROCESS. PLEASE FILL OUT THIS FORM AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITY AND SYMPTOMS.

1. What is your **primary complaint** that brings you here? Please describe your symptoms as specifically as possible.

Secondary complaint?

2. **When** did your symptoms begin? _____

3. **How** did your symptoms begin? For example, did your symptoms begin as a result of an accident or trauma, or did they begin without a known cause? (Use back of form if necessary)

4. Please rate your pain on a 0-10 scale, with a 0/10 meaning no pain and a 10/10 meaning the worst pain imaginable.

- On a good day /10 Location of your pain? _____

- On a bad day /10 How would you describe your pain? _____

- Today's pain /10

5. **WHAT ARE YOUR GOALS FOR THERAPY?** Please list five (5) ***functional limitations*** that are a result of the issue(s) for which you are seeking treatment. Please do not list recreational limitations. This is important for developing an appropriate plan of care.

1.

2.

3.

4.

5.

6. **PAST MEDICAL HISTORY**: Please list any/all surgeries (including cosmetic surgeries), traumas, accidents, or other conditions (and the year they occurred) that you have had throughout your life; even those you do not think have impact on your pain.

7. What activities worsen your pain?

8. What activities/interventions help with your pain?

9. Have you received physical therapy for your current condition? If yes, was it helpful? Have you received any other intervention (chiropractic, massage, acupuncture, etc.) and was it helpful?

10. Are you currently taking any medication (prescription, over-the-counter, and/or herbals and supplements)? If yes, please comment on their effectiveness. Please list all medications and use a separate sheet if needed.

11. Is there anything else that would be helpful for us to know?

Please read fully before signing.

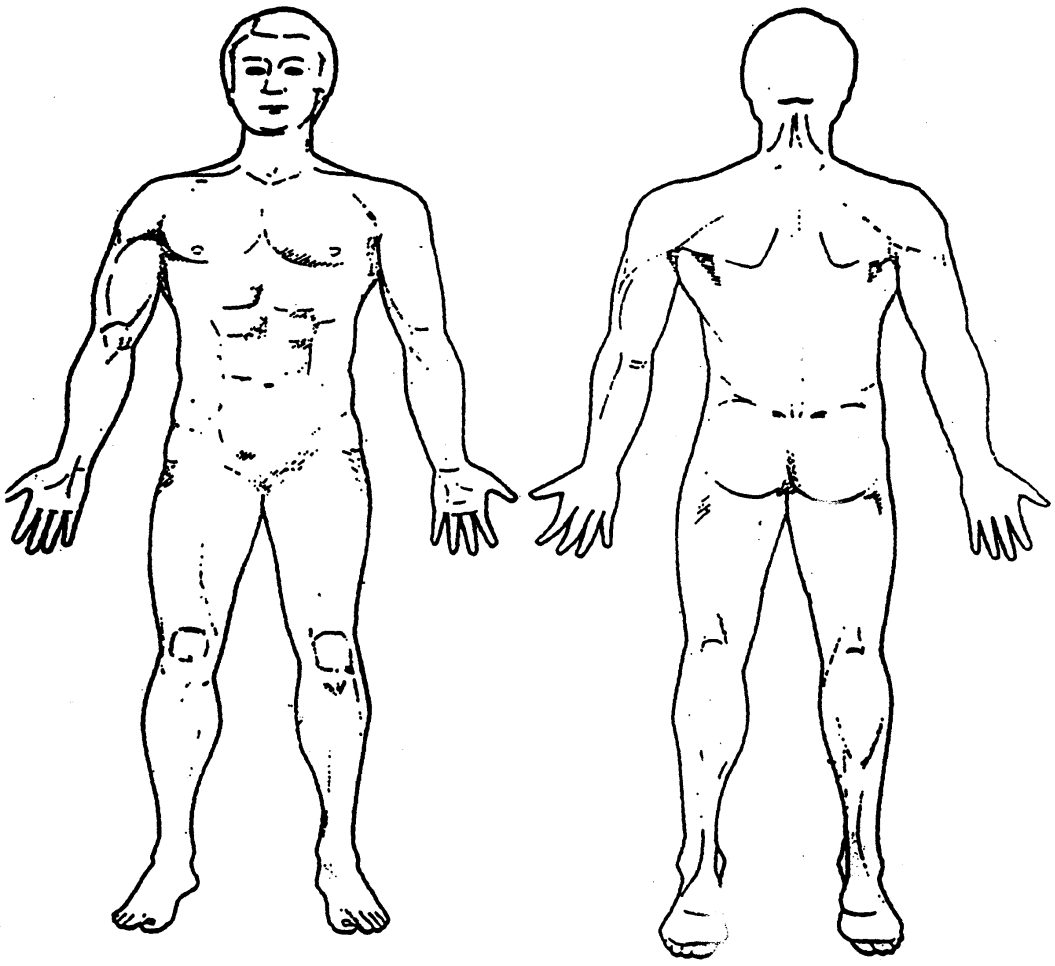
I agree to give 24 hours notice in the event of a scheduled therapy session cancellation. If a minimum of 24 hours' notice is not given, whether by email or phone message, I agree to pay a $50 fee. Late payment fees must be paid before any follow-up sessions are allowed.

For treatment provided on and Out-of-Network basis, I understand that my healthcare provider may not reimburse therapy services and services rendered are not contingent on reimbursement.

_____ _____

Signature Date

IMPORTANT
Please Shade Area(s) of Pain —



Please shade areas of pain or dysfunction. Indicate any scars.

The Pain Relief Center is located at:

980 Westfall Road
Building 100
Suite 105
Rochester, NY 14618.
585-244-6180

980 Westfall is just east of the corner of Westfall Rd. and South Clinton Ave. and directly across the street from the Clinton Crossing complex. Look for the sign shown below at the entrance to the complex on Westfall Rd.