MEMPHIS MYOFASCIAL RELEASE

95 South Main Street Suite 105 | Memphis, TN 38103
P 901-435-6045 | F 901-202-7581 | memphismfr.com

**NEW PATIENT INTAKE FORM**

**PERSONAL INFORMATION** **Date:_______________**

Name:_______________________________________________________________________________
Last First Middle initial

Home address: _________________________________________________________________________
Street City State Zip code

Telephone: Home____________________ Work______________________ Cell_______________________

Date of birth:____________ Age_____ Sex____ Future appointment reminder: phone call text e-mail

E-mail address: _________________________________________ Marital status: S M D W

Emergency contact :__________________________________________________________
Name Relationship Phone

**MEDICAL INFORMATION**

Reason for being seen: _____________________________________________________________________

Primary Care Physician: __________________________ Referring Physican:___________________________

Date of last doctor's appointment: ________________

How did you find out about Memphis MFR? ________________________________________________________

**EMPLOYER INFORMATION**

Occupation: _____________________________________ Employer:__________________________________

Number of years in this line of work: _______________

**INSURANCE INFORMATION** (Please provide card for photocopy)

Primary Insurance carrier:______________________________________________________________________

Secondary Insurance carrier: ___________________________________________________________________

***I hearby consent and authorize the administration of all procedures. I hereby authorize Memphis Myofascial Release, LLC to release or obtain any information acquired in the course of my treatment to the insurance company, attorney, or referring physician, as applicable to my case.***

***I also assign and request payment of medcial benefits to Memphis Myofascial Release for medical services. I understand and agree (regardless of my insurance status) that I am ultimately responsible for the remaining balance of my account for any professional services rendered.***

_______________________________________________________________________________
Signature of Responsible Party Date

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### *New Patient Consent and Disclosure of Health Information*
### *For treatment, payment, or healthcare operations*

I, ___________________________________________, understand that as part of my health care, Memphis Myofascial Release, LLC originates and maintains electronic health records describing my health history, examination, test results, symptoms, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and therapy treatment.
- A means of communicating among the many health care professionals whom contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third party payers can verify that services were provided and properly billed.
- A means of obtaining payment from your insurance carrier and/or you, the client.
- And, a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out therapy treatment, payment, or health care operations.

I understand that Memphis Myofascial Release, LLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Memphis Myofascial Release, LLC reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Memphis Myofascial Release, LLC change their notice, they will send a copy of any revised notice to the address provided, by my requested means (U.S. mail, fax, or e-mail)

I wish to have the following restrictions to the use or disclosure of my health information:

______________________________________________________________________________

______________________________________________________________________________

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

______________________________________________________________________________

Signature of Responsible Party Date

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## *Welcome to Memphis Myofascial Release*

We would like to take this opportunity to thank you for choosing our clinic; we look forward to assisting you in your healing process. We aim to provide the expertise, guidance, environment, and therapeutic treatment to help you achieve your goals and return to a pain-free, healthy & active lifestyle.

Myofascial Release is a whole body, hands-on treatment approach where therapy is applied directly on the skin without the use of lotions or oils. Because of this, the skin will need to be accessible as much as possible during the treatment session. **Please do not put any lotion on your skin prior to treatment**, as it makes it difficult to administer the myofascial release techniques. We suggest that clients wear loose fitting gym shorts and females wear a bra, sports bra, or a swimsuit top.

A typical treatment session is approximately 1 hour long. However, your first visit will include a thorough evaluation and will last approximately 1 ½ hours. Photographs taken during the initial evaluation and re-evaluations will be used for postural comparison purposes and as education tools for postural awareness training only (They will not be sent to your doctor.)

Please be advised that the insurance coverage for these services is dependent on the contract between you your insurance provider. We will contact your insurance company to determine what services are covered, the percentage of the coverage, and the contract limits of your plan. We will do our best to keep you informed, but ultimately you are responsible for understanding your coverage limits and will be held responsible for services or exercise equipment that is not covered by your insurance plan.

If we are out of the network for your current insurance provider, you have the option of filing your own insurance and receiving the services at a reduced fee. If you elect this option, payment is due at the time of service. We will provide a receipt for each treatment session as requested. We can assist you in filing and insurance will reimburse you directly, depending on your out-of-network benefits. Please understand that the exact percentage depends upon your plan.

**By signing below, you agree and understand the above and below terms to treatment:**

- *Wearing appropriate treatment clothing is important for my therapist to see my body structure and have as much access to my skin as possible.*
- *There may be some residual soreness and/or emotional releases following treatment sessions. Drinking lots of water and following up with stretching at home, or applying ice or heat to the affected area will help. This will resolve in a few days and I will let my therapist know about this and ask any questions I need for support.*
- *In order to get the most out of this MFR treatment program, receiving multiple sessions per week for the first few weeks, in addition to active participation in my home exercises is best.*
- *I will let my therapist know of any changes in my medical condition or medication regime.*
- *My appointment time is made specifically for me, if I have to cancel my appointment I will provide at least 24-hr notice in order to avoid a cancelation fee of $75.00*
- *I am aware that payment is expected at time of service, this includes my co-pay and/or payment for treatment sessions in full if I am out of network and filing on my own.*

Signature of Responsible Party ____________________ Date