3601 GENERAL ELECTRIC ROAD, SUITE 5
BLOOMINGTON, IL 61704
(309) 452-0704
FAX (309) 452-0555
WWW.HOPECENTERFORPAIN.COM

Thank you for choosing HOPE Center for Pain for your healthcare needs. Please arrive 15 minutes early to complete necessary paperwork. Please provide us with a physician's referral prior to your first treatment.

INSURANCE POLICY:

Insurance varies and therefore it is the patient's responsibility to know what their coverage is for physical therapy. It is also the patient's responsibility to know if preauthorization is required. Reimbursement from insurance providers is varied. Please be sure to check your policy and/or call the customer service phone number on the back of your insurance card to find out what your physical therapy benefits are.

Participating Provider: The only insurance company that HOPE Center for Pain is contracted with is Blue Cross/Blue Shield. Therefore, services at HOPE Center for Pain would be covered at the in-network rate and insurance claims will be submitted for you. You will be responsible for any portion not covered by insurance.

Non-participating Provider: HOPE Center for Pain is not responsible for insurance claim submission and therefore reimbursement from your insurance carrier is your responsibility. You will be provided a diagnostic receipt containing all the information necessary for claims submission. Please call your insurance company prior to claims submission to find out if there are any extra forms you will need to complete and mail with your receipt. It is also a good idea to mail the physician's referral with the first claim submission.

Medicare/Medicaid: HOPE Center for Pain is not a provider for Medicare or Medicaid.

FINANCIAL POLICY:

- Payment in full is required at time of service.
  Physical Therapy Evaluation, $120.00-$360.00
  Physical Therapy Treatment, $100.00-$270.00
- Cash, Check, Visa, MasterCard, Discover, and Debit accepted for payment.
  There is a $25.00 returned check fee.
- **Cancellation Policy**: I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $60.00.
- *If you are more than 15 minutes late for your appointment, you will be billed for that portion of the missed appointment time. Insurance is only billed for actual therapy time.*
- **Release of Medical Records**: I authorize the release of my medical records to my physicians/primary care provider or insurance company.
- **No warranty**: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for, or improvement in, my condition.

I have read and understand the information above. I understand that any part not covered by insurance is my full responsibility. I agree that if my account becomes past due and is placed with an agency for collection purposes, I agree to pay all collection agency fees (which are typically 33-50%), reasonable attorney's fees and court costs.

PATIENT (or Parent, if minor) SIGNATURE Date

3601 General Electric Road, Suite 5
Bloomington, IL 61704
(309) 452-0704
Fax (309) 452-0555
www.hopecenterforpain.com

Date: ____________________

Patient information:

Name: ____
Last First Middle Initial

Address: ____
Street Apt#/Unit#

____
City State Zip Code

Home Phone: _________________________ Email address: __________________________

Cellular Ph: _________________________ Business Ph: ___________________________

Date of Birth: ________/________/________ Marital Status: S M D W (Circle One)

Social Security Number: ____

Employer: ____

Occupation: ____

Emergency Contact: Name ____
Phone____

How did you hear about us?? (check one): ____ friend _____ family _____ radio
____ television ______ doctor__________________
_____ other:_____________________________________

Name of referring physician: ____

What is the complaint that brings you here?

____
____
____

Have you had previous treatment(s) for this problem? _____ No _____ Yes
If yes, explain____

Lifestyle:

Briefly describe your work environment, work station: (ex: I sit at a computer 75% of the day)

____
____

Do you use tobacco products? No________ Yes ______, amount______________________________

Do you drink alcohol? No _______ Yes________, amount____________________________________

Do you drink water? No _______ Yes________, amount_____________________________________

Do you drink caffeinated beverages? No________ Yes_______, amount_________________________

Do you exercise? No________ Yes________
If yes, type &: how often? ____
____

Medical History:

Previous operations (Type and Date)

____

____

Medications you currently take (Name and Dosage) OR ATTACH LIST

____

____

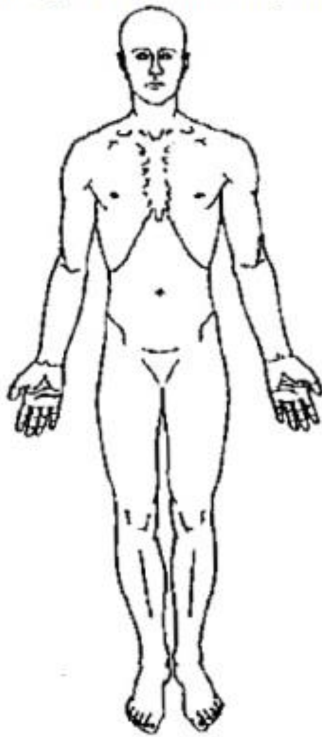
Medical diagnoses (Name and Date)

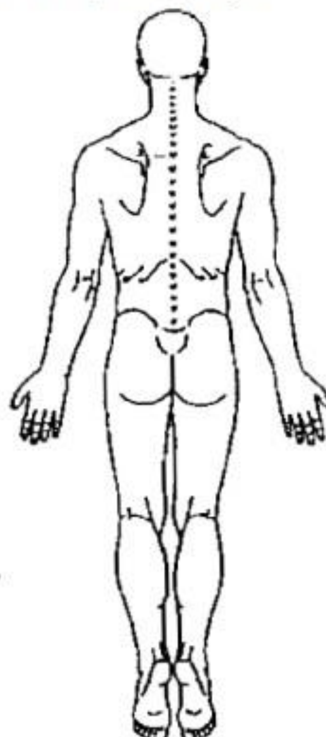
____

____

____

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.





SEVERE PAIN	*******
MODERATE PAIN	00000000
DULL ACHE	∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

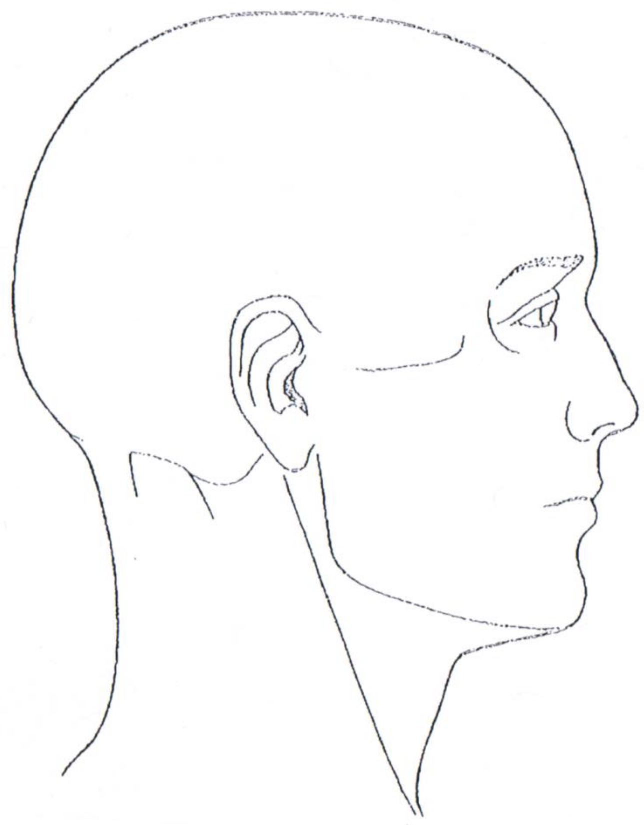
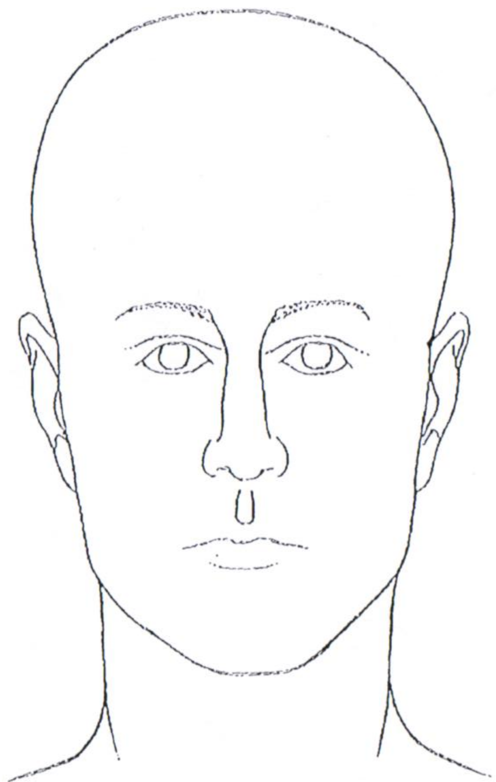
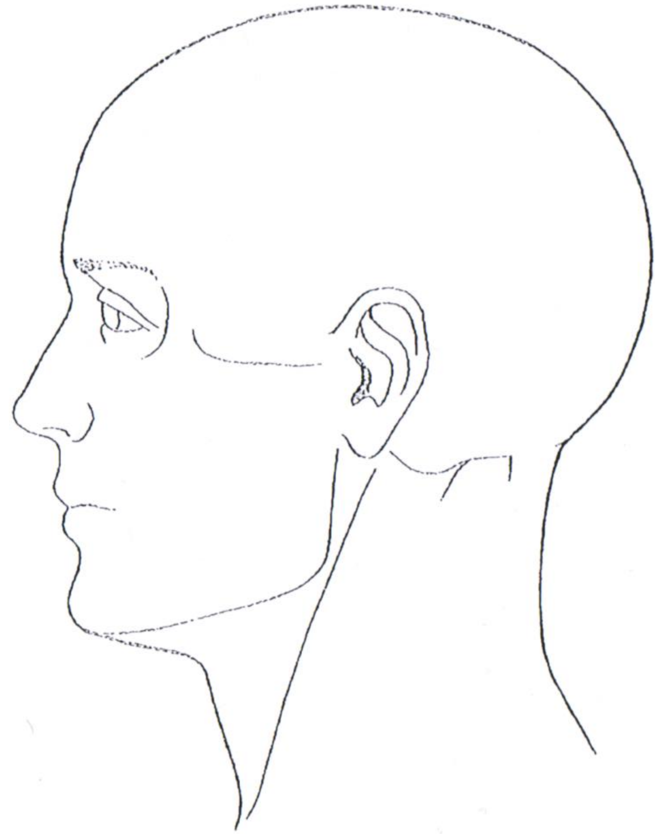
Last Name: ______________________ First Name: ______________ Date: ____________

Perceived Pain Index (PPI): 0 = NONE, 10 = WORST (Circle one number below)

0 1 2 3 4 5 6 7 8 9 10

Please place a mark on the area where you experience pain and use the letters below to describe the pain. You may use more than one letter on each area of pain.

B=Burning S=Stabbing A=Aching N=Numbness I=Itching P=Pins/Needles

3601 General Electric Road, Suite 5
Bloomington, IL 61704
(309) 452-0704
Fax (309) 452-0555
WWW.HOPECENTERFORPAIN.COM

INTEGRATIVE DRY NEEDLING CONSENT FORM

Integrative Dry Needling involves placing a small needle into the tissue that is tender with the intent to normalize the physiology of the area and regain homeostasis, which will improve the function of the musculoskeletal system resulting in symptom reduction.

Integrative Dry Needling is a valuable treatment for musculoskeletal pain. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Risks of the procedure:
Though unlikely, there are risks associated with this treatment. The most serious risk associated with Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptom of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from Dry Needling is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily fluids?
YES _________ NO _________
If you marked "YES", please discuss with your practitioner.

____
Please print your name.

____
Signature Date

3601 General Electric Road, Suite 5
Bloomington, IL 61704
(309) 452-0704
Fax (309) 452-0555
WWW.HOPECENTERFORPAIN.COM

CUPPING THERAPY CLIENT RELEASE FORM

Information has been provided to me about Cupping Therapy, including the potential effects and after care recommendations.

Information on the Contraindications of Cupping Therapy have been provided to me and any health information pertinent to the therapist, I have disclosed prior to Cupping Therapy.

It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from the body. I also understand that this discoloration/reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by my circulatory systems. I understand that the discolorations will dissipate anywhere from 2 hours to as long as 2 weeks in some cases.

I understand that my body's immune system can temporarily react to Cupping Therapy producing flu-like symptoms such as nausea, headache, body aches. These will subside in time with rest and water.

I understand that after Cupping Therapy I should avoid alcohol and caffeine, and I should drink plenty of water.

I understand that prior to and after cupping I should avoid shaving, sun exposure. I also should not participate in Cupping Therapy when I am thirsty or hungry.

I understand that I should avoid hot showers, extreme weather conditions, baths, saunas, hot tubs, and aggressive exercise for 4-6 hours after Cupping Therapy.

I ____ agree to allow the Cupping Practitioner perform Cupping Therapy. I also agree that I have read, understand and will follow all of the information above and will not hold the practitioner responsible.

Date__________________ Signature of Client ____

Printed name:____

PRIVACY NOTICE
HOPE Center for Pain

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.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

HOPE Center for Pain
3601 General Electric Road
Suite 5
Bloomington, IL 61704

I. Uses and Disclosures of Protected Health Information

HOPE Center for Pain may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the group has obtained your authorization or the use of disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. **Treatment**. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. **Payment**. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for services to be provided. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. **Operations**. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of HOPE Center for Pain and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. **Other Uses and Disclosures**. As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your treatment date, to inform you of potential treatment alternatives or options, to inform you of health-related benefits or services that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. **When Legally Required**. We will disclose your protected health information when we are required to do so by any federal, state or local law.

B. **When There are Risks to Public Health**. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted or required by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as permitted or required by law.

C. **To Report Suspected Abuse, Neglect or Domestic Violence**. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. **To Conduct Health Oversight Activities**. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. **In Connection with Judicial and Administrative Proceedings**. We may disclose your protected health information in the course of any judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **For Law Enforcement Purposes**. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. **To Coroners, Funeral Directors, and for Organ Donation**. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. **For Research Purposes**. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. **In the Event of a Serious Threat to Health or Safety**. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. **For Specified Government Functions**. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. **For Worker's Compensation**. The facility may release your protected health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted without Authorization by with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your treatment or payment related to your treatment. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which You Authorize.

Other than stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights.

You have the following rights regarding your protected health information:

A. **The right to inspect and copy your protected health information**. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other reports that this facility uses for making decisions about you.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to the protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.
We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.
To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in compliance with your request. Please contact our Privacy Officer if you have questions about access to your medical records.

B. **The right to request a restriction on uses and disclosures of your protected health information**. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.
The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location**. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The right to request amendments to your protected health information**. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. **The right to receive an accounting**. You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to October 1, 2007. Accounting request may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. **The right to obtain a paper copy of this notice**. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide you a copy of the revised Notice through in-person contact at your next visit.

VII. Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

ATTN: Privacy Officer
HOPE Center for Pain
3601 General Electric Road, Suite 5
Bloomington IL 61704

The Privacy Officer can be contacted by telephone at 309-452-0704.

IX. Effective Date

This Notice is effective October 1, 2013.

- -

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

______________________________________ ______________________
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient ____