Masset Acupuncture & Physical Therapy Center

1900 L Street, N.W., #204
Washington, DC 20036
T: (202) 429-0007 • F: (202) 429-8966
www.masset-integrativecare.com

NEW PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Date: _____

D.O.B.: _____ Age: _____ Insurance Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email: _____

Date of Injury: _____ Date of Surgery: _____ Occupation: _____

Diagnosis: _____ Referring Physician: _____

How did you Learn about us? _____

Emergency Contact Name: _____ Phone: ( ) _____

OFFICE POLICIES AND PROCEDURES

Insurance - Masset AC & PT Center does not participate with any insurance plans, and is not enrolled in the Medicare program. We will provide you with all the necessary documentation to file a claim with your insurance company. Be advised that some insurance plans require pre-certification, prescriptions or referrals for physical therapy or acupuncture services. It is your responsibility to meet the requirements of your insurance plan. However, please feel free to contact me with any questions that you may have.

Payment - The Initial evaluation is $205 and follow-up visits are $174 (depending on the treatment). Payment is required at the time of service (Cash, Check, Visa and Master Card accepted). You will be responsible for any interest or attorney fees incurred for collecting any unpaid balances.

Scheduling - Your appointment time is set-aside specifically for you. If you are running more than 5-10 minutes late, please call to let me know. No reminder calls are given prior to appointments, so please be sure that you have made a note of your appointments. If you have a busy schedule and need some specific times, it is advised that you book your appointments 3 - 4 weeks in advance.

Cancellation Policy - Cancellations must be made at least 24 hours prior to the scheduled appointment or a cancellation fee equal to the amount of the regular appointment will be charged. This fee is due upon the next visit (or no later than 30 days if no appointment is scheduled. This fee cannot be billed to your insurance.

Medical Records Requests - A minimum fee of $50 fee will be charged to send requested documents for legal purposes.

You are attesting that you have read and signed the Notice of Privacy Practices form and received a copy of the office policies and procedures. You also authorize Masset Acupuncture & Physical Therapy Center to use the appropriate techniques for treatment.

Signature: _____ Date: _____

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CONSENT FORM

Patient Name: _____

Address: _____

I do hereby consent to be treated with acupuncture or dry needling by Michele Masset who is a Licensed Acupuncturist and a Licensed Physical Therapist.

I understand that acupuncture and dry needling is performed by insertion of a needle through the skin, with or without the use of electrical stimulation, with or without the application of heat (moxibustion) or other techniques (Cupping, Tuina, Guasha, myofascial release) at acupuncture or at trigger points.

I understand that certain adverse effects may result from treatment. These could include but are not limited to: Slight bleeding, bruising or soreness at the insertion site. Fainting or syncope are rare but may occur with a patient who is highly anxious, extremely fatigued or hungry.

I understand that there is no guarantee concerning the effect of the treatment provided to me. I also understand that I am free to discontinue the treatment at any time.

I understand that this form of treatment is not a substitute for Western Medical treatment and if I am under the care of a Physician for a particular ailment or condition, I should continue my care until advised otherwise by my doctor.

I have carefully read and understand all the foregoing and I'm fully aware of what I am signing.

_____ _____

Patient Signature Date

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OFFICE POLICIES AND PROCEDURES (PATIENT COPY)

Welcome and thank you for choosing Masset Acupuncture & Physical Therapy Center. Here is some useful information clarifying some of the policies and procedures of Masset AC & PT Center. Thank you for carefully reading through the information provided below.

Insurance

Masset AC & PT Center does not participate with any insurance plans, and is not enrolled in the Medicare program. We will provide you with an itemized receipt that has all the necessary information for you to file with your insurance company. Be advised that some health plans may require pre-certification, prescriptions and/or referrals for reimbursement of physical therapy and acupuncture services. There may also be other visit limits and plan restrictions. It is your responsibility to know and meet the requirements of your insurance plan; however, please feel free to contact me with any questions.

Payment

The Initial evaluation is $205 and follow-up visits are $174 (depending on the treatment). Payment is due at the time of service (Cash, Check, Visa and Master Card accepted). You will be responsible for any interest or attorney fees incurred for collecting any unpaid balances.

Scheduling

Your appointment time is set-aside specifically for you. If you are running more than 5-10 minutes late, please call to let me know. No reminder calls are given prior to appointments, so please be sure that you have made a note of your appointments. If you have a busy schedule and need some specific times, it is advised that you book your appointments 3 - 4 weeks in advance.

Cancellation Policy

Cancellations must be made at least 24 hours prior to the scheduled appointment or a cancellation fee will be charged, equal to the amount of the regular appointment. This fee is due upon the next visit (or no later than 30 days when the patient does not have appointment) and cannot be billed to insurance.

Referrals & Prescriptions

The District of Columbia no longer requires a physician's referral or prescription for physical therapy or acupuncture care. Regardless of the D.C. requirement, some insurance companies will require a physician's referral or prescription to process your claim. It is recommended that you check with your health insurance about their physician's referral policy, and comply with it. If a prescription is required, you are responsible for keeping it current.

Medical Record Requests/ Legal Fees

A minimum fee of $50 will be charged to send requested documents for legal purposes.

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Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 [HIPPA] requires all health care records and other individually identifiable health information [protected health information] used or disclosed to us in any form. Whether electronically, on paper, or orally, be kept confidential. This federal law 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 health information.

Without specific written authorization, we are not permitted to use and disclose your health care records for purposes of treatment, payment and health care operations.

Treatment means providing or managing health care and related services by one or more health care providers. Examples of treatment would include therapeutic exercise, neuromuscular reeducation, mobilization, etc.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your health insurance for your physical therapy services.
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 include a periodic assessment of our documentation protocols, etc.

In addition, We may release your PROTECTED HEALTH INFORMATION to:

- remind you of an appointments [by phone or mail] or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you.
- by public health authorities that are authorized by law to collect information.
- Health oversight agencies for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- law enforcement official for any circumstance required by law.
- a medical examiner or coroner to identify a deceased individual or to identify the cause of death or for funeral directors to perform their jobs.
- organizations that handle organ, eye tissue procurement or transplantation, including organ donation banks, as necessary if you are an organ donor.
- reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- federal officials for intelligence and national security activities, if you are a member of U.S. or foreign military forces, including veterans. federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
- correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a] for the institution to provide health care services to you, [b] for the safety and security of the institution, and/ or [c] to protect your health and safety or the health and safety of other individuals or the public.
- workers' compensation and similar programs.

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.

In regards to your PROTECTED HEALTH INFORMATION you have 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.
- receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- access, inspect, and copy your PROTECTED HEALTH INFORMATION.
- request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- obtain a paper copy of this notice from us upon request.
- file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We are required by law to:

- maintain the privacy of your PROTECTED HEALTH INFORMATION
- to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.
- 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. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

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 SW, Washington, DC 20201
877-696-6775 [TOLL-FREE]

With my consent, Masset Acupuncture &Physical Therapy Center may use and disclose my protected health information about me to carry out treatment, payment and health care operations

_____	_____	_____
Name of Patient [please print]	Signature of Patient	Date