Thank you for your interest in Manual Therapy of Nashville, for specialized physical therapy in orthopaedic manual physical therapy (OMPT) with emphasis on wellness and prevention.

Prices are as follows:

Initial OMPT Evaluation plus Treatment	$185.00 (1 hour)
Initial OMPT Evaluation plus Treatment	$245.00 (90 minutes)
60-minute OMPT Treatment (recommended)	$150.00 (1 hour)
90-minute OMPT Treatment	$210.00 (90 minutes)
45-Minute OMPT Treatment	$130.00 (45 minutes)

Scheduling and payment are online at: http://manualtherapyofnashville.com and click on "Schedule an Appointment."

Location is: 95 White Bridge Road, Cavalier Building, Suite 304. The sign on the door says "Touch Therapy."

For most conditions, home instructions will be given for starting a home program, including pain relieving techniques, posture and ergonomic instruction, and/or therapeutic exercises. These instructions are very important to the success of your therapy.

You will need a doctor's prescription for physical therapy in hand **before** the first treatment if you are planning to file with your insurance company. You can see a physical therapist for up to six visits, or one month, without a doctor's order in Tennessee. Clients who are receiving benefits from Medicare are only allowed to see a non-participating physical therapist for maintenance/wellness care which is not covered by Medicare.

Clients are responsible for filing their own insurance claims, and if you are planning to I strongly recommend that you call your insurer and verify your coverage prior to your first visit. All insurance plans are different. Please do not assume that your insurance will cover your therapy. Be sure to ask if your insurer offers different deductibles or different coverage for out-of-network-providers.

However, if you have a Health Savings Account (HSA), these funds can usually be used for physical therapy services.

Contact me if you have any further questions. Again, thank you for your interest in Manual Therapy of Nashville. It is an honor to be of service to you.

615-356-1524	74 Brookwood Terrace	240-751-7578
Fax	Nashville, TN 37205	cell

Patient History Form

Date: ______________

Name: _________________________________ Date of Birth:__________ Age:_______
Address: ____
email: _______________________________ Physician: ___________________________
Phone: ____________________(home) __________________(work) ________________ (cell)
In the event of an emergency contact: ______________________ contact number: ____________

Circle any of the following that apply to you:

high blood pressure	diabetes	currently pregnant
heart disease	breathing problems	history of seizures
osteoporosis	cancer	arthritis – osteo or rheum?
infectious disease	intestinal disorders	thyroid condition
circulation disease	paralysis/stroke	skin sensitivity
dizziness	headaches	mental/nervous disorders
vision problems	balance problems	falls

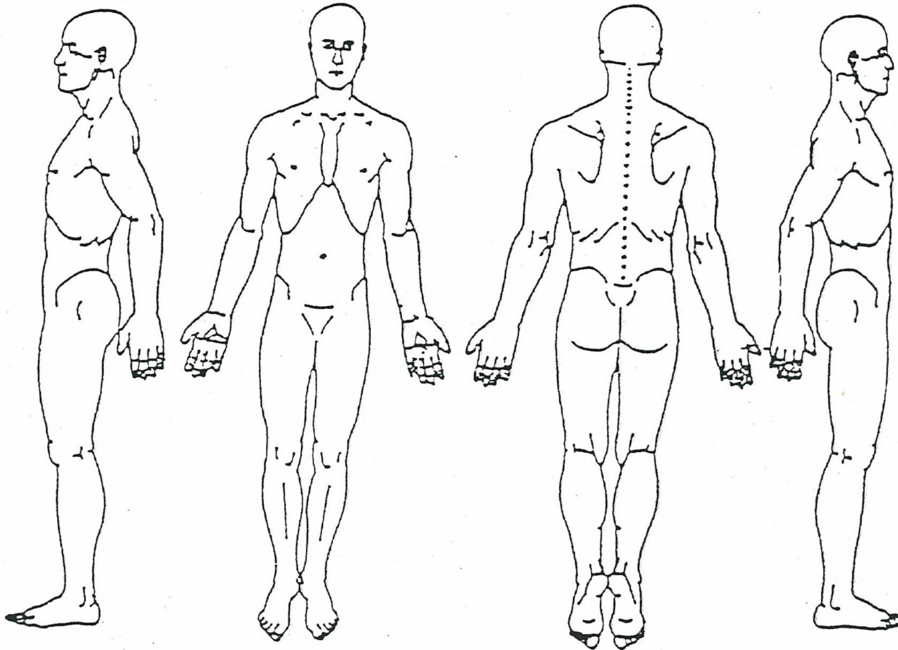
other: ____
allergies (please list) ____
____

Do you have any disease or infection that can be transmitted through bodily fluids? Do you have clotting disorders? Are you on blood thinners?

YES NO

Have you had a motor vehicle accident or other trauma? Yes or No
Was there immediate pain or delayed pain? (circle one)
Did you have loss of consciousness? Yes or No
Past surgeries____
____
Do you have any popping or clicking? Yes or No. Where? ________________________
Is the popping/ clicking accompanied by pain? Yes or No.
Do you have headaches? Yes or No. Where? ____________ How often? ____________
Do you experience discomfort when you cough or sneeze? Yes or No
Have you had any recent change in your bowel or bladder habits? Yes or No
Have you had any recent change in your weight (greater than ten pounds)? Yes or No.
Does your discomfort ever wake you at night? Yes or No
Overall are your symptoms improving the same or worsening? (circle one)
What medicines are you taking?
____
____
Have you had any tests for your present condition? (please list)
____

Patient History Form page 2 Name: _________________ Date: _________



Draw on the figures where you feel your pain, numbness, or tingling.

Also, indicate a number on a scale (0-10) next to the area of pain. 0 is no pain.

Answer the following for each of your problem areas (copy and paste or use back):
Describe what your problem is and how it started:

____

____

____

Date of onset or injury:_____________ Did symptoms start suddenly or gradually?
Prior to the current problem were you free of discomfort where you have it now? Y or N
If no, what treatments have you tried and what were the results?

____

____

Is your discomfort constant or do you have times that are pain free? (circle one)
Pain (or other symptom) worst in morning midday evening night? (circle one)
Pain (or other symptom) least in morning midday evening night? (circle one)
What activities or positions aggravate your symptoms?

____

____

What activities or positions relieve your symptoms?

____

____

Patient History Form page 3 Name: ___________________ Date: __________

Exercise History:

Do you currently exercise? Yes or No

What do you do for exercise? ____

____

____

How often? _____________________________

Distance? ______________________________

Do you have a certain type of shoe? _________________ Orthotics? _________

What is your goal for exercise/ training? _________________________________

Do you follow a certain training program?_________________________________

Do you have a particular trainer? ____

Do you participate in any races or other competitions? Please explain (include distances and how often): ____

____

____

Are there any activities or recreations that you would like to return to?

____

When was the last time that you did this activity or recreation? _____________

PRESCRIPTION FORM

Patient Name:______________________________________Date: __________

Diagnosis/ ICD-9 Code:____

____

_

PHYSICAL THERAPY EVALUATE AND TREAT:

_____ROM/joint mobilization
_____Soft tissue mobilization
_____Stretching
_____Strengthening
_____Core Strengthening
_____Functional Exercises
_____Neuromuscle e-stim/ re-education
_____TDN (Trigger Point Dry Needling)
_____Education/Ergonomic training
_____Other:_________________________
_____Therapeutic exercise
_____General conditioning
_____Home program
_____Self Treatment
_____Taping
_____Orthotics
_____Neuro e-stim unit
_____Heat/cold instruction

_________________________________ _________________________

Physician Signature Date

____

Print Physician Name

615-356-1524
(Fax)

74 Brookwood Terrace
Nashville, TN 37205

240-751-7578
(Cell)

NO SHOW/ LATE/ CANCELLATION POLICY

Appointments are scheduled and paid for online at www.manualtherapyofnashville.fullslate.com. If you should need to change or cancel less than 24 hours in advance of your appointment, Full Slate will charge the full fee for the treatment session because it means a non-productive time-slot for MTN and MTN would rather keep charges lower, rather than be forced to increase them to defray the cost for missed appointments. If you are less than 15 minutes late, you may choose to be treated for the remainder of the time; however, the charge will remain the same. If you are more than 20 minutes late, then the therapist has the choice whether to continue with treatment; however, the charge will remain the same.

PAYMENT POLICY

Manual Therapy of Nashville, LLC does not accept insurance or third party payments. Most appointments are scheduled and paid for online at www.manualtherapyofnashville.fullslate.com. Please contact MTN if you need assistance, or would like to discuss accommodations. I understand that I am solely responsible to be informed of my insurance plan's policy on co-pays, deductibles, and coverage and to file my insurance that pertain to my physical therapy at MTN, an out-of-network provider. I understand that I am financially responsible for all charges.

RELEASE OF MEDICAL INFORMATION/ PRIVACY POLICY

My medical records will only be released to my referring physician/referring physician's staff and to myself by email, mail, or fax, unless otherwise requested in writing. Exclusions to this policy are only as necessitated to comply with State Worker's Compensation Laws, in the event of an emergency, as required by law, in the course of a judicial proceedings, for research as described below, to prevent or lessen a serious or imminent threat to another person or the general public, or if MTN is sold or merged with another organization. MTN may contact me by phone, text, mail, or email for purposes of scheduling appointments, client paperwork/ reports or to respond to questions about my condition, treatment, response to treatment, or plan.

I authorize the use of my medical records for medical or scientific research, which allows researchers to learn new or better ways to evaluate and treat injuries or illnesses. Research results do not identify individuals by name or any other personally identifying characteristics. This authorization does not expire but may be revoked or limited by me, in writing, at any time.

DIRECT ACCESS ATTESTATION

In Tennessee, if you want to see a physical therapist without a doctor's prescription you can choose to do that for up to six visits or thirty days, whichever comes first. If you would like to receive physical therapy services without a doctor choose one of the following options:

I, __________________, **do not have** a licensed doctor of medicine, chiropractor, dentist, podiatrist, or doctor of osteopathic medicine for my injury/condition that I am being evaluated and treated by.
I, __________________, choose direct access to physical therapy services and **would like to forgo** the right to have a licensed doctor of medicine, chiropractor, dentist, podiatrist, or doctor of osteopathic medicine informed of the initiation of physical therapy treatment.
I, __________________, choose direct access to physical therapy services and **would like** the following licensed doctor of medicine, chiropractor, dentist, podiatrist, or doctor of osteopathic medicine informed of the initiation of physical therapy treatment.

Signature: ________________________________ Name: __________________________________
Date: ____________________

CONITIONS AND CONSENT FOR PHYSICAL THERAPY EVALUATION AND TREATMENT

We at MTN are committed to serving you and making your experience enjoyable and successful. Thank you for choosing us as your partner in health and fitness. You have a choice in health care providers, and we aim to exceed your expectations.

Informed consent for treatment:
The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Treatment options for your condition may include, but are not limited to: range of motion, stretching, strengthening, motor re-training, and balance exercises, soft tissue mobilization, joint mobilization, neurophysiological exercises, home exercises, trigger point dry needling, dermal dry needling, electrical stimulation, posture and ergonomic education, self-treatment instruction, taping, cupping, massage, neurological re-education.

Potential benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities and recreational activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks: I understand that the most common risk is that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort, or any other symptom, is usually temporary: if it does not subside in 24 hours, I will contact my physical therapist. Although, unlikely, other risks include fracture, lung puncture, stroke, or loss of life.

No warranty: I understand that my physical therapist at Manual Therapy of Nashville, LLC cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me his/her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

You have the right to decline any treatment option that is offered to you and alternatives will be discussed. I have been given the opportunity to ask questions about the evaluation and treatment options, or any other questions that I have.

Alternatives: If I do not wish to participate in the therapy program. I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

I have read the above information and I consent to physical therapy treatment. By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

I do hereby consent to such treatment by the authorized personnel of Manual Therapy of Nashville, LLC as may be dictated by prudent medical practice by my illness, injury, or condition.

Authorized Signature: Today's Date: / /