WALT FRITZ, P.T.
PAIN RELIEF CENTER

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.

Email address: _____

(Please Check) I agree to allow Walt Fritz, PT, to contact me via email and text message for notification of upcoming scheduled appointments or routine correspondence: ___Yes ___No

Health Insurance Company and complete 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 ME WITH A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITY AND SYMPTOMS.

1. What is the **primary concern or complaint** that brings you here? Please describe your symptoms as precisely as possible.

Secondary concern or complaint?

Have you had any tests for this issue (X-ray, MRI, etc.)?

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

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

4. Please rate your pain on a 0-10 scale, with a 0/10 = no pain and a 10/10 = worst pain imaginable. If you are coming for more than one area of complaint, please use the back of this page to report pain levels.

- 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 a few ***functional limitations*** that result from the issue(s) for which you are seeking treatment and what your goals are regarding these limitations.

1.

2.

3.

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 to have an impact on your pain or condition.

7. What activities worsen your pain?

8. What can you do to help/lessen your pain?

9. Have you received any intervention for your current condition?

- o Physical Therapy
- o Chiropractic
- o Massage
- o Acupuncture
- o Mental Health Counseling

10. Are you taking any **medication** (prescription, over-the-counter, herbal, and supplements)? Are they helpful? Please list all medications and use a separate sheet if needed.

11. Is there a chance you might be pregnant?

12. Is there anything else that would be helpful for me to know?

13. What is your expectation from your visit(s)?

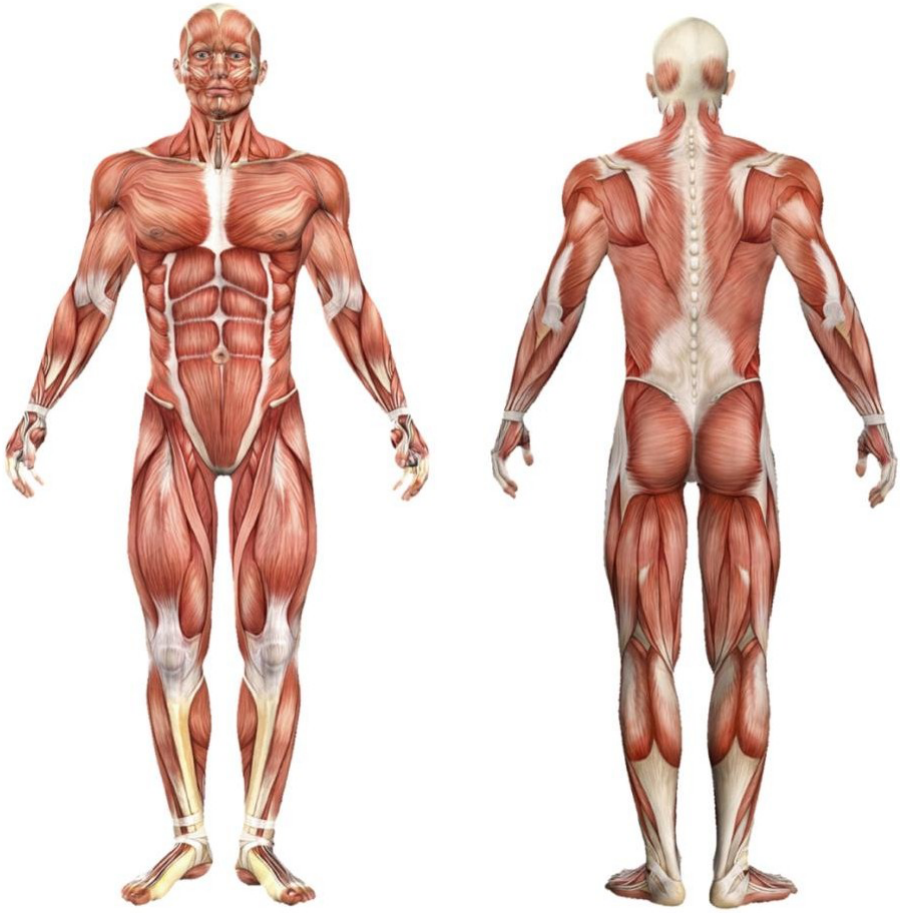
Please read thoroughly before signing.

I understand that email/text reminders are automatically sent (via email and text message) to me 48 hours before every session and that I agree to give 24-hour notice in the event of a scheduled therapy session cancellation. If a 24-hour 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 an 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** _____

On the diagram below, please mark areas of pain or dysfunction. Indicate any scars.



I aim to help you achieve as pain-free and functional a state as possible. Your first visit will involve evaluation as well as treatment. Please note: You do not need a current prescription for physical therapy from a physician, dentist, or podiatrist within the first 30 days of your first session, regardless of insurance policy statements regarding the need for a referral. This policy applies whether your insurance is paying for your treatment or if you are paying privately. I will be happy to assist you in obtaining a prescription from your doctor.

As of March 8, 2025, the Pain Relief Center will be out-of-network (OON) Excellus/Blue Cross Blue Shield.

I accept Aetna, Medicare, MVP/Preferred Care Gold (Medicare), TriCare, Independent Health, POMCO, and No-Fault (Motor Vehicle) as In-Network insurance. I do not accept Medicaid. Insurance-based sessions run approximately 25 minutes. All other insurances, including Cigna, United Health Care, and regular MVP/Preferred Care, would be considered Out-of-Network (OON). We will gladly request clarification on your policy to determine if services are covered. In-network coverage allows you to pay a co-pay or co-insurance after your deductible has been met, and your insurer pays the rest directly to the provider (the Pain Relief Center). If OON (Cigna, United Health, etc.), full payment of the session fees is expected at the time of service, and you may receive reimbursement for some of the session fees if your policy covers OON physical therapy (see below). I do not accept Workman's Compensation insurance, and out-of-pocket payments are not allowable. The out-of-network and private pay rates for sessions at the Pain Relief Center are $65/25-minute, $130/50-minute, and $260/100-minute sessions.

When assessing out-of-pocket costs, please remember that during each session, you will have the undivided attention of Walt Fritz, PT, throughout the entire session. Unlike traditional physical therapy, where most patients exercise on their own with occasional supervision from the physical therapist, treatment at the Pain Relief Center involves 100% of your time with one-on-one intervention from myself. Payment for treatment may be made by HSA cards, Flex-Spending cards, credit/debit cards, checks, or cash and is expected at the time of service.

Out-of-Network Coverage for Physical Therapy: If your health insurance allows you to submit bills to them for reimbursement and also allows you to see an out-of-network physical therapist, you may receive payment for a portion of your fees. You will be provided with the necessary documentation, in the form of receipts and progress notes, to assist you in receiving reimbursement from your health insurance company. Submission for reimbursement will be your responsibility. You should 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 you answer "no," you will not receive any reimbursement for the fees paid, though you can use a flexible spending account/card or HSA. If "yes," ask what the coverage entails. A typical response would be, "You have a $250 deductible, and then you are covered for 75% of expenses after the deductible is met". If in doubt, please contact me for more questions regarding your specific insurance. The fees for OON physical therapy are at the private pay rate of $65/25 minute session or $130/50-minute session. Please understand that your insurer will reimburse you based on their maximum daily rate for physical therapy reimbursement. For some insurers, this is $65. So, if your OON coverage were 80%, you would be eligible for 80% of $65, even if you paid the 50-minute session rate. This reimbursement disparity is why I do not accept some insurance as an In-Network Provider.

Scheduling: You may do the scheduling process via the online booking site. The link for this is on the website www.LimaPainRelief.com. You can book sessions to meet your scheduling needs through the online booking site. My schedule is Monday-Friday. Since therapy at the Pain Relief Center is hands-on, I request that you ***bring appropriate clothing*** to facilitate this process. Depending on your issues, please bring a loose-fitting T-shirt or tank top along with a loose-fitting pair of shorts of thin material (not denim shorts, please) if you are coming for lower body issues. Many times, treatment is done over your regular clothing. If you have specific concerns in this area, please let me know. **I ask that you refrain from wearing 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 me. I may not be able to start on time on rare occasions, usually because the previous session is taking slightly longer than expected. I ask for your understanding and assure you that you will receive an entire session. Also, be assured that at some point, if you need a more extended session, you will always be afforded the same consideration. For this to work, you must 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 I can attempt to fill the vacant appointment. **A 24-hour notice is required for cancellations to avoid payment of a $50 fee.**

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 I use or disclose 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," I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your information. I may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination.
- **Payment** means obtaining service reimbursement, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill for your visit to your insurance company for payment.
- **Healthcare 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.

I may also create and distribute de-identified health information by removing all references to individually identifiable information. I 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. I must honor and abide by that written request, except that I have already taken actions relying on your permission. You have the following rights concerning your protected health information, which you can exercise by presenting a written request:

- The right to request restrictions on specific 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. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I 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 me 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 me upon request.

I am 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 concerning protected health information.

This notice is effective as of **December 1st, 2023,** and I must abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information I maintain. 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 this notice's provisions or our office's policies and procedures. I 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, _____(signature), acknowledge that I have received and understand the **NOTICE OF PRIVACY PRACTICES** from Walt Fritz, PT, and the Pain Relief Center, 7303 East Main St. (Mailing address is PO Box 548), Lima, NY 14485, on _____(date) and understand the no-show/late cancellation penalty.

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

1. _____
2. _____
3. _____
4. _____

_____
(Patient Signature)

The Pain Relief Center is located at 7303 East Main Street, Lima, NY 14485. The mailing address is PO Box 548, Lima, NY 14485

East Main St in Lima is Routh 20 & 5. The office is located directly on the northeast corner of Route 20 & 5 and Routh 15A (Rochester St/East Henrietta Rd). There is on-street parking on both streets and off-street parking just east of my office in a small municipal lot. Please use the BACK door of my office, located on Rochester St).

NOTE: *Due to the set-up of the office, the door will be locked while I am working with a patient. If you arrive early for your appointment, you cannot enter the office until approximately 5 minutes before the scheduled start time. The Milk and Honey, The Lima Diner, and the American Hotel are across Main Street from the office, should you wish a place to grab some coffee or tea while you wait. Vanilla Lane can satisfy your baked good sweet tooth!*

Google Maps: https://goo.gl/maps/foCPGTzKhbZLszfs8