RONALD S. MURRAY PT, CTN

5411 W. Cedar Lane #202A, Bethesda, MD 20814
2311 M Street NW #301, Washington DC 20037
Website: www.RonMurrayWellness.com
Appointment (240) 492-8434

4833 Rugby Avenue #200, Bethesda, MD 20814
5012 Dorsey Hall Drive #205, Ellicott City, MD 21042
Email: RonMurrayWellness@gmail.com
Fax (240) 489-8434

Welcome New Patient,

We want to welcome you to the RSM PT at the Asclepeion Center for Body Mind Therapy. We are proud that you have chosen us to be a partner in your healthcare team. We also want to congratulate you for choosing to look at alternative treatments in your health. This is where our partnership and journey begins.

Dr. Murray is trained not only in traditional methods of physical therapy, but also in various new techniques aimed at (1) gently freeing any areas of restricted movement in the body and encouraging the natural healing abilities of the body to return to its optimal functioning level and (2) helping individuals to explore any psychological, as well as physical components of their pain syndromes and/or disease processes. Our website has information and brochures that will give you a sense of the work that we will be doing together.

Our professional mission is to provide a comprehensive evaluation and treatment protocol that will address not only the physical causes of your problem, but also any emotional components as well. We have found in our work that there is almost always a somato-emotional component to intractable health problems, chronic and acute pain syndromes, and deeply ingrained patterns of muscular tension. We make every effort to provide a safe space for our patients within which they can face and release any emotional trauma that has caused them to develop rigid pain-producing patterns of muscular tension.

Your initial treatment will last 90 minutes. We also strongly suggest each patient undergo a “Heart Rate Variability Analysis” (HRV) during at your 2nd treatment. The HRV is a non-invasive test that takes about 10 minutes to administer. It’s an excellent indicator of general health and the health of the nervous system. Your following treatments are 60 minutes, unless Dr. Murray feels you would benefit for a longer treatment session. RSM Physical Therapy is fee for service provider which means payment is due at time of treatment. All of our treatments are insurance reimbursable (based upon your policy) under your Physical Therapy benefit and as a courtesy, we submit the insurance claim forms for your insurance company. The insurance company will then send any reimbursement directly to you.

In order to expedite your initial treatment, please fill out the enclosed Patient History Form and bring it to your first visit. Be sure to fill it out in detail so we have a full sense of your medical history and past treatment. If you would like for us to submit the insurance claims for you, be sure to complete the insurance information page.

In closing, we would like to say that we believe a person with chronic pain and/or health problems recovers faster when actively participating in the healing process. The focus of our work is to help you “listen to your body’s needs” so you can then help it to reclaim its natural healing potential. During the time that we work together, we urge you to become your own co-therapist deciding, with our help and input of course, what blend of treatment modalities works best for you. We look forward to meeting with you and beginning our work of bringing greater health and healing into your life!

Have a Healthy Day,
-Dr. Ron

TELL US ABOUT YOU

A well-founded relationship is based on getting to know one another. Please complete the entire Registration and Health History form. The information you provide will ensure the best treatment, aid with diagnosis and treatment planning as well as help identify any precautionary measures needed to protect you. The information you provide is STRICTLY CONFIDENTIAL and will be protected.

Patient's Name:		Date of birth:
Email Address:		
If minor, Parent/Guardian Name:		
Relationship to Patient	Referred by	
Street Address		
City	State	Zip Code
Cell Phone	Alternate Phone	
Occupation	Employer	
Marital Status	Sex	
Primary Care Physician		Phone number
Do you have health insurance? Y N		Do you want RSM PT to submit claims for you? Y N
Insurance Company	Relationship to Policy Holder	
Name of Policy Holder	Policy Holder Date of Birth	
Insurance ID #	Group #	
Insurance company address		

TELL US ABOUT YOUR MEDICAL HISTORY

Health problems and/or medications, have an important interrelationship with the care you will receive. Our medical history questionnaire is extensive so we thank you in advance for taking the time to complete. This information will allow us to provide you with the best care.

	Y	N	If yes, please explain
Are you currently under a physician's care?			
Have you ever been hospitalized?			
Have you ever had surgery?			Use space below
Are you taking any medications?			Use space below
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			
Do you drink coffee?			
Do you drink alcohol?			
Do you have any allergies?			Use space below
Are you pregnant?			
Are you nursing?			

Please list all surgeries with dates

_____ _____

_____ _____

_____ _____

Please list all medications and dosages that you are presently taking including supplements and remedies

_____ _____

_____ _____

_____ _____

_____ _____

Please list all known allergies, environmental and chemical sensitivities and reactions

_____ _____

_____ _____

_____ _____

Please let us know if are experiencing or have experienced any of the following conditions and when you began experiencing these conditions:

	Month/Year		Month/Year		Month/Year
Headaches		**Neck Pain**		**Shoulder Pain**	
Lower Back Pain		**Dizziness**		**Sinus Congestion**	
Ringing in the Ear		**TMJ**		**Pain when Chewing**	
Facial Weakness		**Facial Pain**		**Jaw Pain**	
Muscle Twitching		**Fatigue**		**Anxiety**	
Depression		**Upper Back Pain**		**Concussion**	
ADHD/ADD		**POTS**		**PANDAS/PANS**	

What are your specific complaints/symptoms you are seeking relief? Please list major complaints first

Symptoms	Month/Year		Month/Year
1		**4**	
2		**5**	
3		**6**	

When did your health concerns begin? Was there any significant event that occurred?

Current Level of Pain
On a scale of 0 to 10 (with 0 being the lowest level of pain) please circle on the scale on the next page where your pain level today falls on the scale.

0. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Please describe any other pertinent information, symptoms, disorder, etc. not yet covered.

Please identify practitioners (besides primary care physician) that you are currently including in your health such as alternative health practitioner, nutritionist, chiropractor, massage therapist, psychotherapist, energy healer, etc.

Name of Practitioner	Type of Practitioner	Practitioner address and Phone Number

Thank you so much for taking the time and effort to fill out this Health History Form.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patients) health. It is my responsibility to inform the office of any changes to my medical status.

If patient is under 18 years of age,
Signature of Parent _____ Date_____

Signature of Patient_____ Date_____

Printed name _____

In case of Emergency, whom should we contact?

Emergency contact name	Phone

RSM Physical Therapy at the Asclepeion Center for Body Mind Therapy

INFORMED CONSENT FOR TREATMENT AND/OR EVALUATION

I, (patient name) _____, hereby give my permission and consent for treatment at the RSM Physical Therapy at the Asclepeion Center for Body Mind Therapy.

- I understand that this may include the intake and diagnostic assessment process as well as may therapies that may be recommended or prescribed.

- I understand that Ronald Murray is a licensed Physiotherapist licensed in Maryland and District of Columbia and that Ronald Murray is not a licensed medical doctor.

- I also consent that RSM Physical Therapy at the Asclepeion Center for Body Mind Therapy can disclose Protected Health Information for treatment, payment and healthcare operations in accordance with HIPAA.

I understand that all assessment or treatment and evaluation is voluntary, and that treatment will end:

- **When the therapist and I decide that sufficient progress has been made.**
- **At any time I so choose.**

I have read and/or had the above explained to me, and voluntarily give my informed consent to treatment and/or evaluations.

Patient's Name: _____

Signature of Patient (or Parent if patient is minor): _____

Date:_____

Please circle one: ***(Patient / Parent / Conservator / Guardian)***

Written Financial Policy

Thank you for choosing RSM Physical Therapy at the Asclepeion Center for Body Mind Therapy and Ronald Murray, PT, ND for your therapeutic needs. We strive to deliver the most comprehensive therapeutic care available. An important part of this mission is relieving stress of the costs of your care.

Payment is expected at time of treatment. For your convenience, we accept all major credit cards (MasterCard, Visa, Discover and AmEx).

Although RSM Physical Therapy at the Asclepeion Center for Body Mind Therapy does not accept or participate with any insurances as a form of payment, we will submit your claims to your insurance carrier to maximize your benefits. Your insurance carrier will send reimbursement for your treatment directly to you. Since we are not a participating provider with ANY insurance carrier, we are considered an “Out of Network” provider and “Third Party Payer”. As a Third Party Payer, insurance carriers may not discuss your policy with us, so it is the insurers’ responsibility to verify coverage and specifics with the insurance carrier. We are happy to assist, however limited to what we can provide.

_____ **Initial that your understand the financial policy**

Written Cancellation Policy

We know that LIFE happens and you will need to cancel appointments. If you need to reschedule your appointment, we require a minimum of 48 hours’ notice. You can notify us by phone, text or email if you need to cancel within 48 hours. We know your time is valuable. So when you cancel less than 48 hours’ notice or fail to show for your appointment, the primary person being hurt is

- You, because you’re not getting the care you need

Therefore a $75 fee for cancelling an appointment with less than 48 hour notice and/or failing to show for your scheduled appointment.

_____ **Initial that your understand the late cancellation/no show policy**

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT:

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the RSM PT and the Asclepeion Center for Body Mind Therapy. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our *Notice of Privacy Practices* is subject to change.

If you have any questions about our *Notice of Privacy Practices*, please inform the front office staff.

I acknowledge receipt of the *Notice of Privacy Practices* of the RSM PT and the Asclepeion Center for Body Mind Therapy.

Patient's Name: _____

Signature of Patient (or Parent if patient is minor): _____

Date:_____

Please circle one: *(Patient / Parent / Conservator / Guardian)*

For Office Use Only

INABILITY TO OBTAIN ACKNOWLEDGEMENT:

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient Name:_____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices.

_____ Patient refused to sign

_____Communication barriers prohibited obtaining the acknowledgment

_____Other (specify)

_____ _____

Signature of Staff Date

_____

Printed name of Staff

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU AND/OR YOUR CHILD'S TREATMENT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is very important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing competence or qualifications of healthcare professionals, evaluating practitioner and provider performance or conducting training programs.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personal under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT'S RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $.60 for each page, $18 per hour for staff time to locate and copy your health information and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanations as to how payment s will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS:
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated you privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complain upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Monica Wilson
Telephone: 240-492-8434 Fax: 240-489-8434
Address: 5411 W. Cedar Lane #202A, Bethesda, MD 20814