Mind Body Freedom Therapy
4915 Monona Drive Ste 205
Monona, WI 53716

Erin Tauscher MS OTR/L
(920) 839-5139
erin@mindbodyfreedomtherapy.com

Mind Body Freedom Therapy Informed Consent

Myofascial Release (MFR): 'Myo' refers to muscle and fascia is the deep connective tissue that connects every single structure in our bodies. MFR is the gentle application of sustained pressure into the tissue that is hard, hot, or tender (known as fascial restrictions). With sustained pressure over time, the tissue is allowed to release, open, and rehydrate helping you return to a pain-free active lifestyle.

Risks: MFR is a very low risk treatment method. The therapist will never force movement. Your therapist will never guarantee to directly cure or heal a disease. MFR techniques release pressure on your tissues, muscles, and organs which allow your body to function better. After treatment, you may feel energized, tired or therapeutic pain, similar to soreness from working out, which may last between 1-3 days. Eventually you will go through a healing crisis, which means you re-ignite the inflammation response so that your body can clean up the tissue and help you deeply heal. True healing is messy and you must feel the pain of a trauma or past injury in order to heal; feeling is healing. Feeling sensations while mindful, patient, and allowing your body to soften will not harm you. It is only when people force and disregard what their body is telling them, that injuries may occur. Forcing is NEVER a part of this therapy. Please note that healing is a process of improvements and setbacks as your body re-calibrates to the changes and you learn exactly how your body is communicating with you. Please discuss any questions or concerns with your therapist.

Benefits: Research shows MFR is effective in decreasing pain, increasing range of motion, eliminating 'holding' or 'bracing patterns, increasing proprioceptive awareness and increasing functional mobility. Patients have also reported improved sleep, sitting tolerance, standing tolerance, walking tolerance and general well-being.

Role of Therapist: To assess, educate and empower you by leading treatment sessions to help you redefine your relationship with your mind and body.
It is very important to create and sustain a professional relationship. I can only be your therapist due to the natural inequity of power and vulnerability between patients and clinicians. You trust me to protect your personal information and hold a safe container during your therapy process. Therefore, I respect that and keep our relationship professional. I do, however, encourage you to visit, like and follow my MIND BODY FREEDOM THERAPY Facebook, Google, Instagram, Yelp, Bing, and Business Website. I also encourage you to help other people by referring anyone who many benefit from this work.

Complaints or Questions: Please bring any complaints or questions directly to me (Erin). If you would like to contact someone else please contact the Wisconsin State Department of Safety and Professional Services (DSPS) at (877) 617-1565.

Methods of Treatment: Manual Therapy/Myofascial Release Techniques, **Therapeutic Exercise/Procedure, Therapeutic Activities, Neuromuscular Re-education (**Static Postural /Body Awareness Training & Dynamic Movement Awareness Training), **Self Care Techniques (**Stress Reduction/ Relaxation Training, Sleep Hygiene & Energy Conservation)

Timeline: Two to three months of dedicated attendance is highly recommended for you to start to integrate the new knowledge and skills into practice. It is also highly recommended to schedule

appointments more frequently together upon starting. Every single person progresses at a different rate. It depends how much you are able to show up, dedicate yourself, and be open to change. We will work together to find the best frequency and duration of treatment as you progress. The gold standard at John F Barnes Myofascial Release Centers is 30 hours of treatment for radical transformation and change to occur. Every session can help you to integrate, so any amount you are able to show up will have a cumulative effect and help you on your way to achieving your goals.

Cost: The Initial Evaluation and individual treatment sessions are each 60 minutes for $175. This first visit entails discussion of this consent form, a review of past injuries, illness and diseases/diagnoses; range of motion testing; full body tissue analysis, baseline photos (if consenting) and strength testing as needed. Treatment will be initiated during the remainder of the time.
For those dedicated and ready to commit to change, follow up treatment sessions are $165 if you schedule 1 x a week for two months (8 sessions = $1320). So you save $10 a session and $80 total off the session rate. We know what it takes for success. Commitment plus regular sessions really help. Each session includes a baseline check in, treatment, and education in home therapy/release programs as needed or desired. Products for sale include self treatment items ranging from $5-40. Small group classes are $40 each.
This amount is due in full at the appointment. Payment is encouraged by cash, check, or bank transfer. A credit card reader is also available as needed.

We are a fee for service practice which means, we do not submit to insurance. We can get you an itemized receipt that you can submit to your insurance for reimbursement if you are NOT a Medicare beneficiary. Insurance plans may or may not reimburse you for the full amount charged for each session. Please refer to the following Payment Agreement for specific details.
Diagnostic codes used for insurance reimbursement are as follows: 97165 LOW COMPLEXITY EVALUATION (62.50); 97166 MODERATE COMPLEXITY EVALUATION (62.50); 97167 HIGH COMPLEXITY EVALUATION (62.50); 97140 MANUAL THERAPY TECHNIQUES (31.25); 97530 THERAPEUTIC ACTIVITIES (31.25); 97110 THERAPEUTIC PROCEDURE (31.25); 97168 OT RE-EVALUATION (62.50); 97112 NEUROMUSCULAR RE-EDUCATION (31.25)

We do accept credit and debit cards associated with Health Savings Accounts (HSA) only if you have a medically necessary reason for treatment.
If extra services are required that take longer than 15 minutes to complete (i.e. receipt records for lost receipts, letters of medical necessity, external communications, phone call consultations), a fee for the equivalent time will be applied.

Good Faith Estimate - No Surprises Act 2022: The information provided above and below covers all necessary information for the new requirement as of 2022. There are no surprise charges. Each session is billed according to the discussed fee schedule. When there are changes to rates, all clients will be notified prior to scheduling future sessions.

Canceled and/or Missed Appointments: Continuity of care is an important piece of participating in therapy. Frequent cancellations and/or no shows may cause long periods between therapy sessions and impact the effectiveness of your treatment. It is recommended that you consistently show up for therapy and make time to complete the recommended therapy home programs. Participating in a handful of therapy sessions will help in the short term but will not be sufficient to create a lasting change.

If you are unable to keep your appointment and wish to cancel, PLEASE contact me by phone or email at least 48 hours before your scheduled appointment time. If you cancel after that time or no show for your appointment, you will be charged the cost of your scheduled session.You will not be able to book again until your missed session is paid in full. There are emergency situations and those will be reviewed on a case-by-case basis. Your time is reserved exclusively for you when you schedule it.

Collection and Storage of Personal Information: Storage and collection of patient information is in accordance with (HIPAA) Health Information Portability and Accountability Act. Your patient file is locked and can only be accessed by me, Erin Tauscher. Your file will be kept for 7 years in compliance with health record maintenance requirements. Any information shared via electronic platforms, such as email or text, are not protected and therefore it is recommended to limit personal information communication via these avenues.

Limits of Confidentiality and Memorandum of Understanding:
I understand that, as long as I am over age 18, all records and communications related to occupational therapy services are confidential and may not be disclosed without my written consent. There are, however, certain limitations delegated by the law such as:

- If I present an imminent danger to self or others
- If there is suspicion of child abuse or a child in need of protection
- If a vulnerable adult is abused or neglected
- To protect the public from abuse or harm from other professionals
- If a judge sends a signed, valid court order requesting information regarding my treatment
- To ensure the quality of your care in clinical supervision

Every effort will be made to discuss with you prior to the involvement of other professionals.

Patient Rights:

- To withdraw this consent at any time (Please provide in writing)
- To refuse particular occupational therapy interventions
- To receive a referral from another therapist
- To access their clinical medical record or request to obtain copies of their file, subject to legal requirements, even after the therapeutic relationship is completed.
- To terminate therapy services at any time by advising your therapist.

COVID-19 Protocol:
As of March 1st, 2022, Dane County lifted its mask mandate. You are encouraged to wear a mask if you'd like or not. If you wear a mask, I will too. Extra time is allotted for disinfecting with approved agents in between each session.

I have received information on the definition of myofascial release, risks, benefits, role of the therapist, methods of treatment, plan/goals, timeline and costs associated with ongoing Mind Body Freedom Therapy. I have had sufficient time to ask questions and understand the implications of further treatment and expectations for my participation. I understand and consent to the proposed treatment. I also consent for photographs for the sole purpose of evaluation and discharge comparison/self-awareness tool.

Signature: Date:
Date of Birth:

Consent to Examination and Treatment

I hereby consent to an occupational therapy examination and subsequent treatment as recommended by the examining occupational therapist.

Examination. I understand the examination includes providing a medical, social and physical activity history and reporting of my symptoms and complaints. I agree to allow the occupational therapist to perform all physical tests and measures required to identify my treatment diagnosis, problems and prognosis. I understand that some tests and measures may require the occupational therapist to perform a visual inspection of exposed body areas or palpate body parts that are sensitive or painful. I also understand that there are some risks in participating in a physical examination, including but not limited to developing soreness, increased pain, new pain in different areas, an aggravation of existing symptoms or a new injury. I understand that if I am uncomfortable at any time during the examination, I can let the therapist know and may refuse to continue the examination at my choice. If I refuse to participate in any part of the examination, I understand that the occupational therapist may not be able to provide an accurate treatment diagnosis/prognosis or develop the most appropriate treatment plan.

Treatment. I acknowledge that my occupational therapist (hereinafter "OT") has informed me of my diagnosis, prognosis and the potential risks and benefits of all recommended interventions in my proposed plan of care and I have been given an opportunity to have all my questions answered. I hereby agree to participate in and consent to receive the OT interventions recommended by my OT as outlined in my treatment plan. I understand that the response to different OT interventions varies from person to person and sometimes treatment interventions may result in increased pain, an aggravation of existing symptoms or a new injury. Therefore, I agree to inform my OT of any change in my symptoms and function so my treatment plan can be adjusted accordingly. I understand that I may decline any intervention at any time by informing my OT of my desires/concerns and that my refusal may result in a termination of my treatment if my OT determines that there are no other treatment alternatives or the refused intervention is essential to meeting my goals. I also understand that although we have set rehabilitation goals, my OT has made no guarantees that any particular outcomes will result from the therapy interventions.

I have read and understand the benefits and risks involved in participating in an occupational therapy examination and treatment. I consent to the examination and treatment, accept any and all associated risks involved and agree to fully cooperate and participate in the proposed occupational therapy interventions in the established plan of care.

Patient Signature: Date:

Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

☐ I do not consent to any voicemail, email or texting communication.

☐ I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all that you consent to)

- Email
- Text
- Voicemail

☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent to)

- Email
- Text
- Voicemail

Patient Signature: Date:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been given a copy or an opportunity to read the practice's Notice of Privacy Practices on the Mind Body Freedom Therapy Website.

Patient Signature: Date:

Payment Agreement

Thank you for choosing Erin Tauscher, doing business as "Mind Body Freedom Therapy," as your occupational therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) We are out-of-network with all health plans. If you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Medicare Policy (for Medicare Part B and Medicare Advantage Plans).** If you are a Medicare beneficiary, you understand that our licensed occupational therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and we are not equipped to bill Medicare. Since we are not enrolled providers, we cannot submit claims to Medicare *and* Medicare will not pay for our services even though the same services might be paid by Medicare if you obtain them from a Medicare enrolled provider. By choosing to receive our services, you are agreeing to pay privately at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.
    - **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we do not accept Medicare at this location, you agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement of copays, coinsurance or deductibles that your commercial health plan does not pay.
- **Wellness & Fitness Services.** Most commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 6 weeks for 1 month packages and 10 weeks for 2 month packages. If you don't use your visits within that time frame they are null and void. If you request a refund for the unused visits within that the 6-10 week timeframe, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other visits.

- **Use of Health Savings Accounts (HSA).** If you purchase a pre-paid package plan through your HSA account we will give you a receipt for the pre-paid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.

- **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.

- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

Patient Name (Print or Type): _____

X _____ Date: _____

Patient's Signature

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT (OPTIONAL)**

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region.

Treatment may include, but not be limited to, the following: observation, palpation, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction. Benefits of treatment may include an improvement in my symptoms and an increase in my ability to perform my daily 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 and Alternatives. I understand that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist. If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my occupational therapist or treating physician.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No Warranty: I understand that the occupational therapist (OT) cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided.

I have read this consent form, understand the benefits and risks involved in my OT treatment plan, and agree to fully cooperate and participate in the proposed interventions in the established plan of care. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation or want to request having a second person present in the room when I am being treated.

Patient's Name (Printed):

Patient's Signature: Date:

My Testimonial/Recommendation

By writing about your experience and signing below you will potentially help MANY other people to benefit from Occupational Therapy and Myofascial Release.

This form is a good way to describe ***in your own words*** what your experiences have been and how YOU have /are benefiting from this treatment approach.

Please also consider submitting an online review of our practice, you can use your testimonial, at our Google + page https://g.page/r/CTwRRrOKPvOLEBM/review. Many of our patients find us online and mention the reviews and testimonials have helped them.

You can write whatever you like, examples of things to include are:

- How you felt at the beginning, when we started
- How you feel now
- The progress and changes you have experienced

I consent to the use of this information so that others can understand how they too might benefit from John F Barnes' Myofascial Release at Mind Body Freedom Therapy.

Patient's Signature: Date:

Patient's Name:

(Please print your name as you would like it to appear below your testimonial)