Full Name:_____ Date of Birth:_____ Phone#:_____ Email:_____

PATIENT EDUCATION AND VERIFICATION

EMPIRE/NYSHIP Insurance and its many benefits.
The insurance company has entered into a contract with its members for which we, as a service provider, uphold and adhere to. Specifically, part of that agreement states that the insured must pay a deductible and co-insurance.

(A) Please review the agreement between Medical, Massage, Acupuncture and NYSHIP Empire Plan. Your healthcare plan requires the provider to collect any co-insurance and deductibles. IT IS your full responsibility to ensure that, in accordance with your agreement with your insurance company, that you meet all requirements set forth.

(B) Collect-
Have patient **sign "My co-insurance is $_____, 20% My deductible is: $_____ My copay is: $_____**

We do not have the power to change the contract that the patient has with the insurance company even with an out of network policy.

1. Do you have pain, headaches or spasms that may interfere with your daily activity?
2. Currently are you receiving treatment with No/Fault & W/C? You may receive a questionnaire from insurance - confirming N/F & W/C.
3. Patients are afforded ***20 visits*** **for Massage therapy and 20 visits for Acupuncture per calendar year. (July 1, 2023-December 2023= 20 visits honored for remainder of the year.)** ***It is the sole responsibility of the client to keep track of their 20 visits. If treatments are rendered at an alternate provider, those will count towards the 20 visit max, and clients will be responsible for payments on services exceeding the 20 max visit.***
4. ***Patients are afforded 1 (one) visit per week for trigger point therapy.***
5. Prior to receiving any services, you must be **diagnosed by a medical doctor, and have a valid referral & prescription.**
6. Medical massage is billed as Massage Therapy but the EOB reflects **Medical Services.**
7. Acupuncture is billed as Acupuncture but the EOB reflects **Medical Services.**
8. Trigger Point Therapy is billed as TP but is interpreted on the EOB as **Surgery,** when there is **ultrasound** it may be considered as **Radiology.**
9. **ALL INSURANCE CHECKS MUST BE BROUGHT IN WITHIN 30 DAYS OF RECEIPT with signed back of check and EOB. Failure to remit EOB's along with endorsed/signed checks may result in improper credit to your account and could cause delay in processing payments to your account(s).**
10. **Tips** are allowed but not mandatory for massage therapists.
11. **24 hour cancellation policy:** cancellation less than 24 hours **without an emergency** will result in a **$100 fee charged to your card on file.**
12. **PATIENTS MUST GET FOLLOW-UP** VISITS WITH MEDICAL DOCTOR AND RECEIVE PRESCRIPTION FOR MASSAGE OR ACUPUNCTURE SERVICES. Referrals and prescriptions ***must include diagnosis, date of birth, address & phone number of provider.***

Name of person responsible for this and policy holder account: _____ **NYSHIP#** _____

Name of patient being treated: _____ **Phone #:** _____ **Date of Birth:** _____

Credit/Debit Card Information: (please print legibly)

Name of Card Holder: _____ **Card Type:** _____ **Exp .Date:** _____

Credit Card #: _____ **CVV Code (3 or 4 digit #) :** _____

☐ I authorize this medical practice to process the above credit card as "card on file". I understand this authorization will remain in effect until the expiration of the credit card account; patient may also revoke this form by submitting a written request to the medical practice.

- It is the sole responsibility of the patient to make sure that their insurance policy is effective, which is primary and which is secondary if applicable and to inform us of any and all insurance plans and/or changes; insurance policies are an arrangement between the insurance carrier and the patient. Failure to do so will result in the patient being billed for any outstanding claims or money recoveries requests.
- After the verification of your coverage & deductibles and/or copays this office may accept assignment on most policies provided the insured/patient signs and appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor. Any medical or other records or information necessary to process any claims will be released from our office. If you have any questions concerning this or any other matter, please speak with the new patient coordinator.
- If you are unable to make your appointment due to an emergency, please call us and let us know so we can reschedule your appointment. If you need to change the time of your appointment, plan to come another time on the same day. If the same day is not possible, try to make up the missed appointment within one week as not to disrupt your treatment plan. With the exception of an unexpected emergency, we require that you notify us 6 hours in advance as to any appointment changes to avoid being charged.
- For no call/no show appointments or cancellations less than 24 hours in advance, there is a non-refundable $100.00 service charge that will be billed to you or your credit card/debit card on file.

(Client) Print Name:_____ **(Witness) Print Name:**_____

(Client) Sign Name: _____ **(Witness) Sign Name:** _____

Date:_____ **Date:**_____

Client Intake Form – Medwell Management LLC

Personal Information

Name_____Email_____
Phone (Cell) _____Phone (Home) _____
Address_____City _____
State _____ Zip _____ Date of Birth _____
Occupation_____Emergency Contact _____
Emergency Contact Phone _____

The following information will be used to help plan a safe and effective treatment program. Please answer the questions to the best of your knowledge.

Date of Initial Visit _____ Chief Complaint(s) _____
Onset Date (When did the symptoms begin?) _____
Have you experienced these symptoms before? Yes No
Is your pain caused by an accident or injury? Yes No
Date of Injury _____ Nature of Injury: Auto Collision On The Job Injury Other_____
Are you currently working? Yes No If no, when was your last date worked? _____
If yes, any restrictions? _____
Have you ever had surgery for this injury? Yes No
If yes: Type of Surgery _____ Date of Surgery _____
Have you received any medical care/treatment for your current condition/injury(s)? Yes No
If yes, please explain _____
Have you received any physical therapy services this year? Yes No If yes, how many?_____
Have you had a professional medical massage before? Yes No
If yes, how often do you receive massage therapy? _____
Have you had acupuncture treatment? Yes No
If yes, how often do you receive acupuncture treatment?_____
Do you see a chiropractor? Yes No If yes, how often? _____
Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____
Do you have any allergies? Yes No
If yes, please explain _____
Do you have sensitive skin? Yes No
Are you wearing contact lenses, dentures, or a hearing aid? Yes No
Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe _____
Do you perform any repetitive movements in your work, sports, or hobby? Yes No
If yes, please describe _____
Do you experience stress in your work, family, or other aspects of your life? Yes No
If yes, how do you think it has affected your health?
Muscle tension anxiety insomnia irritability other _____

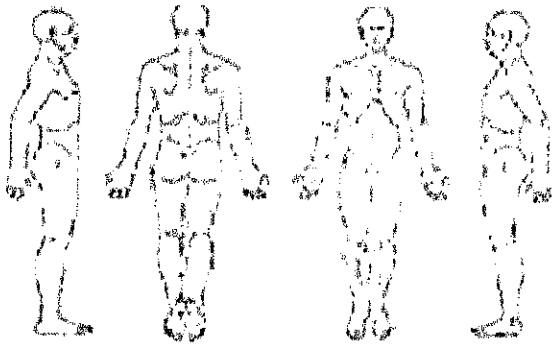
Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please identify _____

Pain Scale

1 2 3 4 5 6 7 8 9 10

Please denote your pain levels on the above scale, circling the number for your current pain level and put an 'X' through the number where you would rate your pain when it's at its worst.



Circle any specific areas you would like the treatment teams to concentrate on during your sessions

How would you characterize your pain(s)? (Circle all that apply)

Sharp Stabbing Dull Aching Burning Numb/Tingling Spasm Stiff Radiating

What makes it better, if anything? _____ How long does it last? _____

What makes it worse, if anything? _____ How long does it last? _____

Are there any activities that are made more difficult by your pain/injury? (I.E. lifting, pushing, etc.)

_____

Are there any areas that you are uncomfortable being touched/massaged during your treatments? Yes No

If yes, what areas would you like us to avoid?

_____

Do you have a preference with a male or female massage therapist? Male Female No Preference

Medical History

Are you currently under medical supervision? Yes No

If yes, please explain _____

Are you currently taking any medication? Yes No

If yes, please list _____

Please check any condition listed below that applies to you:

contagious skin condition	phlebitis
open sores or wounds	deep vein thrombosis/blood clots
easy bruising	joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
recent accident of injury	osteoporosis
recent surgery	epilepsy

artificial joint	headaches/migraines
sprains/strains	cancer
current fever	diabetes
swollen glands	decreased sensation
allergies/sensitivity	back/neck problems
heart condition	Fibromyalgia
high or low blood pressure	TMJ
circulatory disorder	carpal tunnel syndrome
varicose veins	tennis elbow
atherosclerosis	pregnancy if yes, how many months?

Other _____

Please explain any condition that you have marked above:

_____

Is there anything else about your health history that you think would be useful for your treatment team to know to plan a safe and effective treatment plan for you?

_____

Informed written consent must be provided by parent or legal guardian for any client under the age 17.

I, _____ (print name) understand that the massage and/or acupuncture treatment I receive is provided for the basic purpose of relief of muscular tension. If I experience any pain or discomfort during any treatment session, I will immediately inform the therapist so that the treatment may be adjusted to my level of comfort. I further understand that massage and/or acupuncture treatment should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage and/or acupuncture therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage and/or acupuncture should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the treatment team reserves the right to refuse treatment on anyone whom he/she deems to have a condition for which care is contraindicated.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

HIPAA PATIENT CONSENT FORM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND REPORTS

Patient Name: _____

Date of Birth: _____

The Department of Health and Human Services established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to our treatment, care, and payment of health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure that privacy. We strive to always take reasonable precautions to protect your privacy. When it is necessary and appropriate, we provide the minimum necessary information to only those we feel are in need of your health care information, information on your treatment, payments, and/or healthcare operations in order to provide the best quality of care in your interest.

I hereby authorize all health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, and pharmacies, to release all existing medical records and information regarding the above referenced patient's medical care, treatment, physical/medical condition, and medical expenses revealed by your observation or treatment of past, present and future to Medwell Management, LLc, to include but not limited to: New York Wellness Massage, PC, Lotus Massage Wellness, PC, A To Z Medical, PLLC, Exact Medical, PLLC, Starwood Acupuncture, PC, Ubase Life Acupuncture, PLLC, and Kyurim Acupuncture PC.

By signing this form, you consent to our use and disclosure of protected health information to carry out the following: A) treatment, payment, and health care operations to all applicable medical providers, including direct or indirect treatment i.e. release of radiographs, imaging, and/or treatment plans by referring physicians B) obtaining payment from third party payers i.e. insurance companies and C) the day-to-day healthcare operations of our practice(s).

You may refuse to consent to the use or disclosure of your personal health information, but this must be submitted in writing. Under this law, we have the right to refuse to treat should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. Such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability

and Accountability Act of 1996 (HIPAA). You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

The patient understands that (Please initial each item):

_____ Protected health information may be disclosed or used for treatment, payment, or health care operations.

_____ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

_____ The Practice reserves the right to change the Notice of Privacy Practices.

_____ The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.

_____ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

_____ The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

Patient Consent for My Provider to
File an Appeal on my Behalf with my Health Insurance Plan

Provider Name:	**Provider Plan ID Number:**
Provider Address:	
Description of services that may be appealed:	**Date(s) services were provided:**

I agree to allow this health care provider to file an appeal on my behalf with the following health plan if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file an appeal, or stops appealing my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

Print Patient Name:	**Patient Date of Birth:**	**Health Insurance Company:**
Patient Address:	**Patient Insurance ID Number:**	
Patient Signature:	**Signature Date:**	

The above named enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:

Print Representative Name:	**Relationship to the Patient:**
Representative Signature:	**Signature Date:**

Print Witness Name:	**Witness Signature:**	**Signature Date:**

UnitedHealthcare®

Designation of Authorized Representative

Member Name (*please print*)	Date of Birth	Member ID Number	
Member's Street Address	City	State	Zip
Designated Representative's Address	City	State	Zip
Provider of Service			
Date(s) of Service or Proposed Service			

I, _____, am appointing
Print the name of the member who is receiving the service or supply

_____
Print the name of the person/organization who is being authorized to act on the member's behalf

To act on my behalf as my authorized representative for (*check all that apply*)

a complaint an appeal documents from UnitedHealthcare regarding the above-noted service or proposed service.

I understand and agree that:

- This authorization is voluntary;
- my health information may be disclosed to my authorized representative and may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member or Approved Party	Date
If person signing this authorization is not the member, describe relationship to the Member (i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority

MASSAGE THERAPY CLIENT CONSENT FORM

In keeping with the Health Care Consent Act, it is my choice to receive massage therapy. I understand that an assessment is required from time to time to determine suitable treatment for me. The treatment can be interrupted at times in order to facilitate communication and for the massage therapist to obtain feedback from me. I also understand that the information I provided is confidential and it shall not be released without my permission. I am aware that the information I provided can be used in a teaching atmosphere with my identity kept confidential. I am aware that the time slot reserved for my massage includes times for interviewing, assessment, the actual massage treatment, any involving additional therapy, case follow-up, remedial exercises, dressing and changing clothing as required. I am aware that it is not necessary to remove all articles of clothing for treatment and that I can decide to remove only the clothing which makes me feel comfortable. I will give consent to the massage therapist to treat only those body parts for which I give permission. I agree to communicate with the massage therapist at any time that I feel my well-being is compromised. I am aware that I may terminate the treatment at any point during the massage, at my discretion and without reasons. I am aware that I may experience possible side effects from the massage treatment, such as: temporary discomfort within the muscle (24-48 hours post treatment), bruising, headache, and dizziness.

I am aware that the massage therapist and the clinic which provide massage, therapy service is not responsible for any lost, stolen or damaged articles. I have read through and agreed to the above conditions. I also have had the chance to have all of my questions answered before agreeing to and receiving massage therapy treatments. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and I should see my health care provider for those services. I agree to keep the massage therapist updated as to any changes in my health, and I release the massage therapist and Lotus Massage Wellness PC from any liability should I fail to do so.

Client Name	Client Signature	Date

MASSAGE THERAPY CONSENT TO TREAT A MINOR

I, _____parent/guardian of _____ have read and understood the aforementioned statements regarding massage therapy. I authorize Lotus Wellness Massage PC and their therapist(s) to provide massage therapy and body work to my child or dependent.

Client Name	Client Signature	Date

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to LOTUS MASSAGE WELLNESS PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges weather or not paid by insurance, I authorize the use of my signature on all insurance submissions. LOTUS MASSAGE WELLNESS PC may use my health care information and disclose such information to the above named company and their agents for the purpose of payment and determining insurance benefits payable for related services.

Client Name	Client Signature	Date
Witness Name	Witness Signature	Date

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to performance of acupuncture treatment and other Oriental Medicine procedure(s) by the below named licensed acupuncturist and/ or other licensed acupuncturists to now or in the future treat me while employed by working or associated with serving as a back-up for the treating acupuncturist named below including those working at the office or any other office or clinic.

I understand that Acupuncture therapy is not a substitute for medical examination and diagnosis. It is recommended that I see a medical doctor for any physical ailment for which I may seek acupuncture treatment.

I fully understand that: Acupuncture therapy is a safe method of treatment. I have been informed that acupuncture therapy may involve the insertion of several sterile and disposable needles into the skin and realize that some bruising, soreness and superficial bleeding are occasional occurrence(s) near the needle sites that last for a few days.

Cupping bodywork therapy is an adaptation of an ancient technique: the purpose of this technique is to promote health and healing by loosening soft tissue and connective tissue, scarring and adhesion moving stagnation and increasing lymphatic flow and circulation. This therapy utilizes silicone or plastic cups and a vacuum pistol to create suction on the body surface. These cups are moved over the skin using gliding, shaking, popping and rotating techniques while gently pulling up on the cup, or may be parked for a short time to facilitate joint mobilization or soft tissue release. Suction reaches deep into soft tissue, attachments and organs. Another benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them.

Potential Reactions to cupping are temporary and may include:

- Discoloration is due to toxins and old blood being brought to the surface.
- Post tenderness: usually less than experienced from deep tissue work.
- Redness and itching: increased vaso-dilation and/ or inflammation brought to the surface.
- Decreased Blood Pressure: due to vaso-dilation and/ or nervous system sedation.

I understand that: The clinical and administrative staff can review my medical records and all reports, but all my records will be kept confidential and will not be released without my written consent.

I have read or have had read to me, the above consent. I also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures.

I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I may seek treatment.

_____ _____ _____

Patient's name or guarantor signature Date

_____ _____

Signature of Witness Date

Trigger Point & Nerve Block Therapy Surgical Consent

Trigger Point, Joint and Nerve Block injection therapies are considered surgical procedures that treat localized areas of muscle, joint, ligament, tendon and nerve inflammation and impingement which cause pain, restrict range of motion, and prevent proper blood circulation. This form of therapy is performed by licensed medical providers using ultrasound to guide the injections directly to the affected area(s).

These therapies are free of narcotics and steroids, with minimal side effects, no contraindication with any medication, and safe for weekly use in pain management routines as well as preventative care.

Most patients feel no adverse effects at all. Those that do most commonly experience injection site irritation and numbness, which generally resolves within a few hours. Occasionally, patients can experience lightheadedness due to lidocaine/bupivacaine exposure. Uncommon side effects may include localized infection, cellulitis, abscess formation.

As with all medication there may be rare side effects including but not limited to fever, shortness of breath, rapid/slow heartbeat; feeling anxious/confused may be a sign of a more serious condition. Signs of an allergic reaction include severe itching of skin, conjunctivitis, runny nose, swelling of upper/lower lips, cheeks, larynx. Seek immediate medical attention if you experience any of these symptoms.

I have read and understood the risks associated with the surgical procedures of trigger point and nerve block therapy and consent to weekly treatment as deemed appropriate by the practice providers. This authorization is valid until revoked in writing.

Print Name: _____

Signature: _____

Date: _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ (Print patient's name), **("Assignor") hereby assign to** _____ (Print hospital or health care provider name), **("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), **not withstanding any other agreement to the contrary.**

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____
(Print name of Patient)

_____
(Signature of Patient)

_____

_____
(Date of signature)

_____
(Address of Patient)

_____
(Print name of Provider)

_____
(Signature of Provider)

_____

_____
(Date of signature)

_____
(Address of Provider)

Insurance Company Name: _____

_____

NYS FORM NF-AOB (Rev 1/2004)

Insurance Company Phone: _____

Adjuster Name: _____

File/Case #: _____

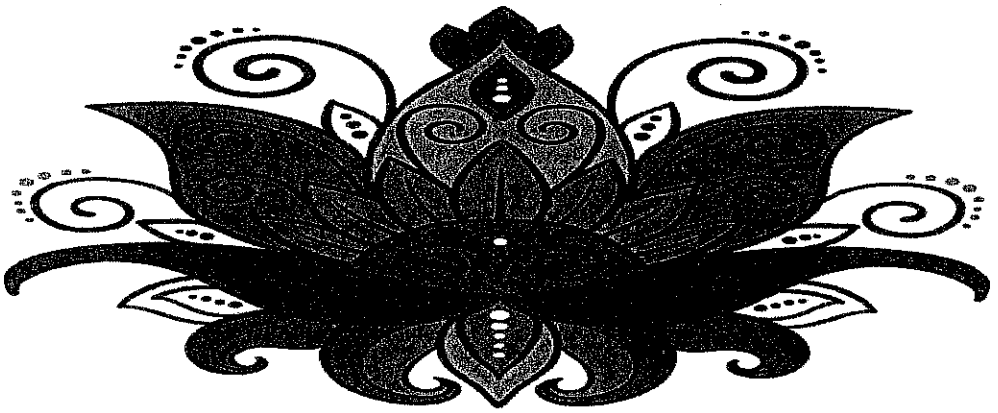
I, _____ have been advised that the medical services I am receiving are being rendered by an ***out of network provider***. As such I agree to the following:

- Claims will be sent to my insurance carrier and payment will be sent to me. I agree to bring in all payments with the corresponding paperwork within 30 days of receiving it.
- Failure to bring in any payments could result in being sent to collections. Collections fees will be applied and I will be responsible for them.
- Failure to bring in any payment and/or paperwork may result in my Medwell account not being properly credited
- I agree to assist the provider and/or billing agents in calling my insurance carrier to confirm payments have been received. If payments have not been received I will have the insurance carrier re-issue a new check.
- It is my responsibility to understand my own insurance.

Patient Signature: _____

Witness Signature: _____

Date: _____



Our office can only provide medical massage referrals for patients who receive pain management.

All others must obtain a referral from your primary care provider before treatment.

****

If you prefer to obtain a referral from your primary prescribing physician – referrals MUST include:

How many sessions (times per week) Medical Massage is recommended.

Area to be treated, necessity for medical massage and/or acupuncture treatment, date of birth, ICD-10 codes as well as medical evaluation and diagnosis.

NEW VISIT LIMIT FOR MASSAGE THERAPY & ACUPUNCTURE SERVICES

Acknowledgement of Receipt/Responsibility of NYSHIP New Reimbursement Methodology for Non-Network Claims effective @ JULY 1, 2023.

Effective July 1, 2023:

There will be a ***maximum of 20 visits*** per calendar year allowed under the NYSHIP EMPIRE PLAN.

Massage therapy provided by a network physician or provider ***will*** also count toward the maximum. Visits to a network Managed Physical Medicine Provider do not generally count toward the 20-visit limit. In addition, any massage therapy ***services rendered prior to July 1, 2023, do not count*** toward the new maximum.

Acupuncture Services provider are subject to a maximum of 20 visits per calendar year beginning July 1, 2023.

The deductible and 20 percent coinsurance will apply. Visits ***prior to July 1, 2023, do not count*** toward the new maximum.

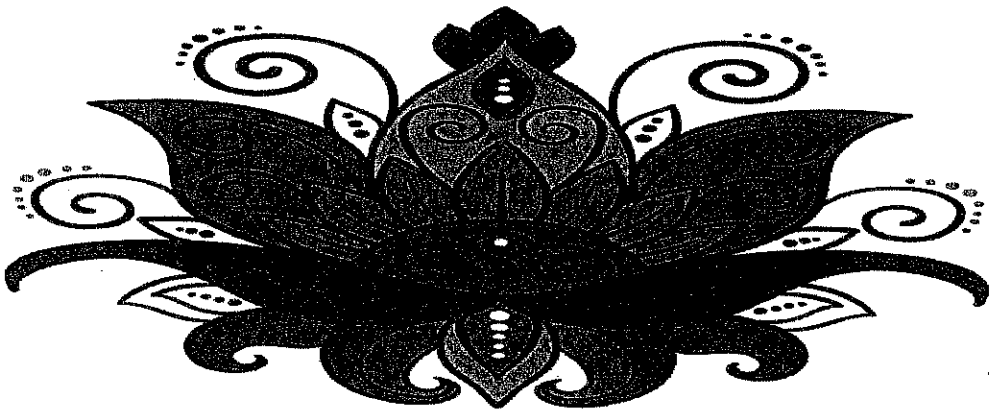
I have read, acknowledge, and understand the above changes pertaining to Massage Therapy and/or Acupuncture Services effective July 1, 2023. I further acknowledge and understand that I am responsible for providing updated/current information pertaining to the aforementioned changes in services.

In the event I receive these services at additional providers, those visits will be counted as part of my 20 visit maximum, and I will be solely responsible for payment in full for each therapy session in excess of the 20 visit max allowable outlined by the NYSHIP EMPIRE PLAN.

***** @ July 1, 2023 - December 31, 2023 = 20 visit maximum *****

***** January 1, 2024 – December 31, 2024 = 20 visit maximum *****

Signature	Print Name	Date
Witness Signature	Print Name	Date



Medwell Spa

IMPORTANT ANNOUNCEMENT:

Due to recent updates within the NYSHIP insurance plan, we are now required to collect a $25.00 co-insurance fee for all massage treatments, effective

JULY 24, 2023.

Please understand that we are mandated to comply with these changes to adhere to the most recent guidelines implemented by NYSHIP.

We look forward to continuing to provide you with exceptional care on your wellness journey.