

Melanie Massey Physical Therapy, Inc.



West Monroe: 107 Summer Lane, WM 71291 **PH** 318-396-1969 **Fax** 318-396-1970
Ruston: 1004 Center Street, Ruston 71270 **PH** 318-232-1969 **Fax** 318-232-1970
Monroe: 4401 Sterlington Rd, Monroe 71203 **PH** 318-388-1989 **Fax** 318-388-1992

Our Mission: To joyfully use our gifts to brighten the lives of others.

WELCOME TO MMPT, INC. FOR INTENSIVE MODEL OF THERAPY!

Thank you for requesting information from Melanie Massey Physical Therapy, Inc., we offer an incredible intensive therapy program with the revolutionary NeuroSuit. We are pleased to combine the NeuroSuit with the experience of our therapists in Occupational Therapy, Physical Therapy, and Speech Language Pathology.

One of our strengths at Melanie Massey Physical Therapy, Inc. is the combined experience of the therapy team in West Monroe, LA. Our clinic has been working in Pediatric therapy for over 10 years. MMPT, Inc. has always been very aggressive in learning and sharing with our patients new techniques that offer hope and the best opportunities available. Therefore, we may include Therapeutic Listening Program, Interactive Metronome, Vision Vestibular Protocol, and/or Brain Train if indicated and recommended by the therapy team.

Enclosed please find information about our intensive therapy program and the price structure and contract. Please contact us for the current 2009 schedule for our three week intensive programs.

Please inform us as soon as possible which session you would like to attend. Space is limited and reservations are made on first-come-first-pay basis in the order deposits are received.

If you have any questions please feel free to contact us:

Phone: 318-396-1969

Fax: 318-396-1970

Email : mmptoffice@mmptinc.com

All of us at Melanie Massey Physical Therapy, Inc. thank you and look forward to seeing you in our program!

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We are excited about the opportunity to work with you to provide the most appropriate intensive session to provide maximal results. Here are some ways you can help us:

For kids: What are some of your kids favorite toys, music, videos (DVD's), games or activities?

For all: Please bring specific goals that you would like us to work on.

Wearing light cotton pants that fit fairly tight (like pajama pants) will be most comfortable during the wearing of the Neurosuit.

A short break time will allow the person in the IMOT program to have a snack. Parents, please bring a healthy appropriate snack for your child. Also, let the therapy team know about toileting needs. We gladly will assist with "potty training" schedules for those for which it is appropriate.

Instructions for Video Tape Screening

(Please provide this video to MMPT 30 days prior to your scheduled IMOT Session)

Dear Parent/Caregiver:

Thank you so much for your interest in our program. In order for us to confirm that your child is a candidate for our program, we would like a 10 to 15 minute video of him/her demonstrating the following activities below. We also need a copy of a bilateral hip x-ray report less than one year old. If you have other reports you'd like us to see, please include them with your video tape. Thanks!



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- Lying down
- Rolling
- Sitting up
- Crawling position
- Crawling
- Tall kneeling
- Standing
- Walking
- Utilizing any assisting devices for the above tasks
- Communicating

Should the patient not be able to perform any of the above tasks, please make a note of this along with your video.

If you have any questions regarding these instructions, please contact Karl at 318-396-1969. Please send your video and the releases to the address below.

Karl Kaufman, P.T.
P.O. Box 1377
West Monroe, LA 71294

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SUMMARY OF SERVICES

Intensive NeuroSuit Therapy

This intensive therapy program consists of 4 hours a day of physical therapy. The child's therapy schedule and activities are personalized to meet his or her individual needs. What makes our program so effective is the *time* we spend with your child to target their deficits and enhance their strengths. This is done through massage, stretching, strengthening, repetitive exercises, use of the NeuroSuit and its methodologies, Universal Exercise Unit, and other methodologies which have been used in Russia for over 14 years. The first day will be an evaluation of 2-4 hours, once the therapist has attained needed information you will have the rest of the day off so that the therapist can begin looking at data and establishing treatment plan and goals. During the last 2-3 days of therapy one session will be a time to re-test to determine amount of progress made.

Our staff of licensed and trained therapists are dedicated to creating and carrying out a therapy program that will produce results! During much of the therapy session there will be 2-3 therapists working with your child. This therapist/patient ratio makes the therapy at Melanie Massey Physical Therapy, Inc. even more effective.

NeuroSuit Therapy

The NeuroSuit, designed by an occupational therapist from the United States, incorporates thick elastic bands used to correctly align the body as the individual is put through exercises to experience "normalized" movements. This retrains the brain and simultaneously strengthens the appropriate muscles through the placement and resistance of the bands. The intensive training our therapists have received gives us the ability to know where to place the bands, which order to train the muscles, and the amount of resistance needed.

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Universal Exercise Unit

This unit is known as the “monkey cage” and the “spider cage”. This unique device uses a system of pulleys to isolate muscle groups and allow for strengthening without allowing other muscle groups to over-compensate. The “spider cage” is a system of bungee cords which allows each individual to experience more independent movements; weight-bearing and shifting, and assisted movements--such as sit-to-stand, quadruped, squats, and even jumping! The therapist guides the child through exercises to strengthen muscles and allows the child to experience precise and controlled movements.

I. How does the suit work?

The NeuroSuit™ is a breathable, soft, dynamic orthotic.

- Improves and changes proprioception (pressure from the joints, ligaments, muscles)
- Reduces patient’s pathological reflexes
- Restores physiological muscle synergies (proper patterns of movement)
- Loads the entire body (anti-musculature) with weight (process similar to a reaction of our muscles to gravitational forces acting upon us for 24 hours).

All of the above normalizes afferent vestibulo-proprioceptive input (information arrives to vestibular system). The vestibular system is tremendously important because it processes, integrates and sends back all the information that arrives from the muscles, joints, tendons etc. It influences muscle tone, balance and position of the body in space.

The more correct the proprioception from the joints, ligaments, muscles, tendons, the better the body’s alignment. This cycle can be interrupted and *new and correct* information can replace incorrect information. To do this, a patient diagnosed with cerebral palsy, or other neuromotor disorder, requires hundreds of repetitions of any particular movement.

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A baby that is trying to push-off the floor will need to repeat this movement a few hundred times in order to master it. Another baby may need either more or less repetitions to learn the same skill. For the person with a neuromotor disability the number of repetitions grows to thousands in order to learn and master new skills.

The **NeuroSuit™** and its methodologies can help correct proprioception and accelerate the progress the child is able to make. Thanks to the **NeuroSuit™** and the intensive physical therapy schedule, the skills practiced will require less and less effort.

II. Indications and Benefits

Indications:

- Cerebral Palsy
- Developmental Delays
- Traumatic Brain Injury
- Post Stroke (CVA)
- Ataxia and Athetosis
- Spasticity (increased muscle tone)
- Hypotonia (low muscle tone) and Hypertonia

Benefits:

- Retrains central nervous system
 - Provides external stabilization
 - Normalizes muscle tone
 - Aligns the body and normalizes gait pattern
 - Provides dynamic correction
 - Provides tactile stimulation
 - Influences vestibular system
 - Improves balance and coordination
 - Decreases uncontrolled movement in ataxia and athetosis
 - Improves body and spatial awareness
-

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Benefits Cont'd:

- Supports weak muscles
- Provides resistance to strong muscles to further enhance strengthening
- Improves speech through head control and trunk support
- Promotes development of both fine and gross motor skills
- Improves bone density
- Helps to decrease contractions
- Vertical loading over the hip joint improves hip alignment
- Restores ontogenic development

III. Contraindications and Precautions

Contraindications:

- Hip subluxation greater than 30%
- Severe scoliosis

Precautions

- Heart conditions
- Uncontrolled seizure activities
- Hip subluxation less than 30%
- Hydrocephalus (VP shunt)
- Diabetes
- Kidney problems
- High blood pressure

Persons with any precaution conditions listed above would need extra medical clearance from their physician to attend an intensive session. Please ask for details.



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Letter of Medical Clearance for Intensive Therapy

Dear Medical Physician,

Your patient is being referred to our program for intensive physical therapy. The intensity is 4 hours per day, 5 days a week for 3-4 weeks. The program consists of exercises causing increased blood pressure, heart rate and respirations. A **NeuroSuit** will also be used which causes increased weight bearing throughout the joints of the body--anywhere from 10 to 30 pounds. This suit is comprised of a vest, shorts, kneepads, shoes and arm attachments that are connected with bungee-type cords to correctly align the body. While wearing the **NeuroSuit**, the patient does a series of muscle-strengthening exercises.

Your patient will be treated by licensed and trained physical therapists.

Please write a prescription for
"PT 5 times a week for 3-4 weeks Eval and Treat"

The child will need a recent bilateral hip x-ray report, less than one year old, mailed to our office 30 days before treatment.

Thank you for taking the time to fill out this information. If you have any additional questions please feel free to contact Karl at our office at 318-396-1969 or at www.mmptoffice@mmptinc.com.

Sincerely,

Karl Kaufman, P.T.
Director, of IMOT at MMPT, Inc.

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Physician Clearance Letter

Date: _____

Patient name: _____ Date of Birth: _____

Diagnosis: _____

Physician's name: _____

Physician's address: _____

Physician's phone: _____

Please review the following conditions and check any that apply:

Cardiac conditions? _____

If yes, please describe _____

High blood pressure? _____

Have a shunt? _____

History of fractures? _____

Bone conditions? _____

Hip subluxation? _____

Please write degree of subluxation for: Right _____ Left _____

- Please provide x-ray report if any subluxation is present

Would you recommend a bone density test prior to an intensive therapy session? _____

Seizures? _____ Are they controlled by medicine? _____

Respiratory conditions? _____

Scoliosis? _____ Degree of curvature? _____

Diabetes? _____

Kidney problems? _____

Any other condition not mentioned in which precautions need to be taken or would make the intensive therapy contraindicated?

I **would** ____ / **would NOT** ____ recommend this patient for your program.

Physician's Signature

Date

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INTENSIVE MODEL OF THERAPY Application

Applicant Information

Patient name:		Male/ Female <small>(Please circle)</small>	
Date of birth:	Diagnosis:	Phone:	
Current address:			
City:	State:	ZIP Code:	
Hip dislocation? ** Yes No <small>(Please circle) ** Written report of X-ray of hip required with application</small>	Scoliosis? ** Yes No <small>(Please circle) ** Written report of X-ray of spine (if scoliosis)</small>	Contractures? Yes No If yes, which joints?	

Family history Information

Parent/ Guardian:		
Current address:		
City:	State:	ZIP Code:
Phone:	Cell phone:	Email:
Employer:	Work phone:	

Emergency Contact

Person to contact in case of emergency(other than above):		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:	Cell phone:	

Patient measurement information

Height:	Weight:	Shoe size:
Circumference of chest:	Waist:	Thigh:



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INTENSIVE MODEL OF THERAPY Application

MEDICAL INFORMATION

Physicians Currently caring for patient: (list all that apply and specialty):

Past Medical History (please include allergies)

Current Medications:

Past and Current Medical Equipment:

Surgical history:

Has patient ever had history of *(Please circle all that apply)* :

Seizures date of last :
Meds:

Fractures

Tracheostomy (Trach)

Vision/hearing problems

Gastrointestinal tube
(G-tube)

Ventriculoperitoneal Shunt
(hydrocephalus)

Heart, lung, kidney problems

Diabetes

Other:

PARENT/ GUARDIAN SIGNATURE The above information is true to the best of my knowledge. I would like to apply for Intensive Model of Therapy, I understand that the cost of the program is \$6,900 and that a \$500 deposit is required in order to reserve a particular IMOT session. (MMPT billing will assist with filing for insurance, but no guarantee of payment can be made.)

Printed Name:

Signature & Date:

____/____/____

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MMPT IMOT CONTRACT/POLICIES

Thank you for choosing **Melanie Massey Physical Therapy** to provide intensive therapy for your child or family member. Below you will find our policies for prices, deposits, payments, insurance and cancellations.

PRICES

3- WEEK PROGRAM (One Session)

60 hours of intensive suit therapy 4 hours per day, 5 days per week for three weeks.

\$6,900.00 (Reduced Rate- Minimum Cash Price)

DEPOSITS

A \$500.00 deposit for an intensive therapy session is required in order to reserve a particular session that you would like your child or family member to attend. This deposit is non-refundable and expires after one calendar year from date of receipt. After a deposit has been received, and you need to cancel your reserved IMOT session, the deposit will be credited to your account for one calendar year for any available session.

PAYMENTS AND INSURANCE

We accept checks, Visa and Mastercard for payment. Melanie Massey Physical Therapy will bill IMOT services to your insurance company at our standard fees for therapy. However, any portion below the minimum reduced cash price of \$6,900.00 that is not paid by your insurance company will be your financial responsibility. We require that you see our billing office to make payment arrangements for any balance that is not covered by your insurance before your IMOT session begins.

CANCELLATIONS/SICKNESS

If your child or family member becomes ill during a session, and is unable to continue and finish the entire session we will work with you to “make up” days missed, as schedule permits when your child or family member is healthy. If your child or family member becomes ill during a session and misses one or two days of the session, those days will not be made up.

I understand that MMPT strives to make IMOT available and affordable based on the clients needs by billing insurance. Therefore, I understand that it is a necessity that my account be paid in full **within 60 days** from completion of the IMOT session, this includes any portion not paid by insurance. I have read the above policies and I/we understand and accept them.

Patient/Responsible Party: _____ Date: ____/____/____

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CONSENT FOR PARTICIPATION/ INFORMED CONSENT WAIVER

Melanie Massey Physical Therapy's Intensive Model of Therapy provides a specialized intensive exercise program for children with developmental, neurological, sensory, mental, orthopedic, and other types of disabilities. There is some element of risk involved with any physical activity/exercise, intense exercise program, and the use of exercise equipment including, but not limited to the NeuroSuit, the Universal Exercise Unit, and Hippotherapy. Although the risk is greatly reduced due to proper supervision, and skilled and trained therapists, there still remains the risk of injury during participation in therapeutic activities. Therefore, it is necessary to get your permission to allow

(Print Patient's Name)

to participate in the exercise program provided by Melanie Massey Physical Therapy, Inc.

I, _____,
(Patient or Parent/Guardian)

Hereby release Melanie Massey Physical Therapy, Inc. owners & employees from any liability, claims, demands, & causes of action, now or in the future, resulting from soreness or injury however caused, occurring during or after my child's participation in the MMPT, Inc. exercise program.

In signing this Consent for Participation/Informed Consent Waiver, I hereby affirm that I have fully read the above statements & understand the inherent risks involved with participation in the exercise program and agree/give permission for my child to participate. I have been informed of risks and complications that may occur and alternatives that may be available. I acknowledge that no guarantees or assurances have been made to me/my child concerning the results intended from the treatment.

In signing this document, I hereby affirm that I have read and fully understand above statements.

Parent or Guardian Signature: _____ Date: _____

Signer's Printed Name: _____

Address: _____

City _____ State _____ Zip _____ Phone: _____



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Standard Photo/Video Release

MMPT, Inc. maintains a website and prints published material which can include photographs/videos of horses, patients, patient's families and therapy sessions. Inclusion in the website and print material is strictly voluntary and is not paid for, endorsed or compensated in any way.

To enable us to include your child/dependent in our website or print material, we require your signature. Thank you!

I, _____, (*print name*) being the parent or guardian of _____, (*print patient's name*) do hereby give full permission to MMPT, Inc., its employees, staff volunteers and any party they designate, to use photographs/video and/or written information of my child/dependent in the MMPT, Inc. website and/or any printed materials.

I waive any rights I have to inspect and approve the finished product, or copy that may be used.

I affirm that I am over the age of 18-years-old and that I am the parent/guardian of the above-mentioned patient.

Signature of Parent or Legal Guardian

Date

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IMOT Patient Information Form for Melanie Massey Physical Therapy, Inc.

Patient Name:		Patient DOB:	
Patient SSN:		Diagnosis:	
Address:		Home Phone:	
City:		State, Zip:	
Check One: () Male () Female		Referring Physician:	

IF THE PATIENT IS A CHILD, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Father:	Mother:
Employer:	Employer:
Home Phone: ()	Home Phone: ()
Work Phone: ()	Work Phone: ()
Cell Phone: ()	Cell Phone: ()
SSN:	SSN:

In the event of an emergency, please contact the following:

Emergency Contact Name:	Emergency Contact Number:
Emergency Contact Name:	Emergency Contact Number:

Insurance Information – Assignment of Benefits

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
Ins. Company:	Ins. Company:
Name of Policy Holder:	Name of Policy Holder:
Policy Holders Relationship to Patient:	Policy Holders Relationship to Patient:
Employer:	Employer:
Policy Holders SSN:	Policy Holders SSN:

Assignment of Benefits: In consideration of services rendered, I _____ hereby irrevocably assign and transfer to Melanie Massey Physical Therapy all rights, title and interest in the benefits payable for services rendered by this medical provider or practice provided in the above mentioned policy or policies of insurance or benefit and welfare plan benefits. Said irrevocable assignment and transfer shall be for the recovery on said policies of insurance or employee benefit plans, but shall not be construed to be an obligation on the part of this medical provider or practice to pursue any right or recovery. Provided, however, this assignment and transfer shall not take away my standing to make a claim, appeal claim denials or sue for benefits individually should coverage be denied by any insurance carriers or employee benefit plan. I hereby authorize the insurance companies or employee benefit plans herein listed above to pay directly to this medical provider or practice all benefits due under said policy or plan by reason of services rendered. I will pay this medical provider or practice for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policies or plans. A copy of this authorization shall be considered as effective and valid as the original. If after this assignment of benefits is executed, I receive directly from any insurer or welfare benefit plan payment for charges incurred, I agree to immediately pay all charges which remain unpaid without regard for the status of my account and whether or not demand has been made by the medical provider or practice.

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IMOT Patient Information Form for Melanie Massey Physical Therapy, Inc. (Continued)

I have reviewed the Assignment of Benefits and I completely understand, agree and accept the conditions outlined.

Signature of Patient/Legal Representative

Date

If the individual other than patient, relationship to patient: _____

Designation of Authorized Representative: I hereby designate this medical provider or practice to act as my representative during an insurance or plan benefits appeal in the event of a coverage denial. I understand that this medical provider or practice has the right to decline or accept the designation at the time the denial is received. If this medical provider or practice accepts this designation, the outcome of any appeal is not guaranteed and I agree to pay all charges which remain unpaid by the insurance carrier or welfare benefit plan regardless of the outcome of any appeal. If the medical provider or practice declines to accept this designation, I agree to pay all charges which remain unpaid by the insurance carrier or welfare benefit plan immediately on demand without regard for the status of any appeal.

I have reviewed the Designation of Authorized Representative and I completely understand, agree and accept the conditions outlined.

Signature of Patient/Legal Representative

Date

If the individual other than patient, relationship to patient: _____

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PATIENT CONSENT FORM

Medical Release for MMPT to Release Records: I hereby authorize Melanie Massey Physical Therapy, Inc. to release to healthcare providers copies of all medical reports, progress notes, physician's orders, itemized statements, and any other documents relating to any examination or treatment pertaining to the said patient. This release also authorizes verbal communication by provider to the party who is to receive medical records.

Authorization for Healthcare Provider to Release Records to MMPT: I hereby authorize all health care providers to release unto Melanie Massey Physical Therapy, Inc. all medical reports, progress notes, physician's orders, itemized statements, and any and all other documents relating to any examination or treatment. This release also authorizes verbal communication by the healthcare provider to the party who is to receive the medical records.

Use and Disclosure of Your Protected Health Information: Your protected health information will be used by Melanie Massey Physical Therapy, Inc. or disclosed to others (i.e. caregiver present at the time of treatment) for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices: You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your protected health information for the purposes of treatment, payment or health care operations.

Melanie Massey Physical Therapy, Inc. may or may not agree to restrict the use or disclosure of your protected health information.

If **Melanie Massey Physical Therapy, Inc.** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. **Reservation of Right to Change Privacy Practices:** Melanie Massey Physical Therapy, Inc. reserves the right to modify the privacy practices outlined in the notice.

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PATIENT CONSENT FORM (cont'd)

Signature: I have reviewed this consent form and give my permission to Melanie Massey Physical Therapy, Inc. to use and disclose my health information in accordance with it for the purposes of treatment, payment & health care operations. A photo copy of this authorization form shall have the same force and effect as the original thereof. Should I wish to revoke any of this authorization, I will be required to request the revocation in writing with the appropriate form obtained from the office personnel.

Signature of Patient/Legal Representative

Date

If individual other than patient, relationship to patient: _____

Signature of Patient/Legal Representative stating that a copy of the Notice of Privacy Practices was received.

Signature of Office Personnel providing copy of Notice of Privacy Practices

Date

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What to send in:

(The items listed below are required in our office
30 days prior to your scheduled IMOT session.)

Please send these to **ATTN: Melissa Cathey**)

- Video Tape
- Physician Clearance Letter (Completed and Signed)
- Prescription from Physician (PT 5x week for 3 weeks Eval & Treat)
- X-ray report on bilateral hips for subluxation
- \$500.00 Deposit for IMOT Session
- IMOT Application
- Consent for Participation/ Informed Consent Waiver
- IMOT Contract/ Policies
- Standard Photo/ Video Release
- List of Goals
- Shoes

Pair of tennis shoes that work with your braces. (\$22.00 fee to have strap sewed onto shoes for use with the Neurosuit. Fee to be paid when you bring the shoes.)

Insurance Information

- New Patient Information Form
 - Patient Consent Form
 - Copy of insurance card (front and back)
 - Copy of Drivers License
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