Jeffrey P. Haggquist, DO, PLLC
Flexibility, Sports & Rehabilitation Clinic
5630 Connecticut Avenue NW, Suite #2
Washington, DC 20015
Tel: 202-244-8222 Fax: 202-244-7432

Welcome to QuistMD – The Flexibility, Sports and Rehabilitation Clinic. Thank you for choosing us as your healthcare specialist! We want you to know what to expect during your visits to QuistMD.

Initial Visit

New patient visits are typically 90 minutes to include an initial assessment with Dr. Haggquist and begin working with a therapist on the treatment plan as prescribed by the doctor. During your initial visit, the doctor will:

- Review your medical history
- Conduct a comprehensive physical exam
- Develop a personalized treatment plan

Therapist Visits

Therapist visits include 55 minutes of treatment with 5 minutes of documentation

- Wear comfortable, loose-fitting clothing
- Restrooms are available for you to change
- We are open as early as 7:30 am Monday – Saturday to accommodate your schedule

Follow Up Visits

As you progress through your therapy, depending on the complexity of the case, every 4-5 visits may consist of a split visit, meaning 30 minutes with Dr. Haggquist and 30 minutes with a therapist. During these follow up sessions, the doctor will:

- Discuss your progress
- Make necessary changes to your treatment plan
- Perform osteopathic manipulation

Home Exercise Program

The core of our therapeutic treatment is Active Isolated Stretching and Strengthening (AIS), a technique that increases flexibility and strength using a short hold to achieve rapid results. You should know:

- You will receive a tailored home exercise program.
- As a member of your care team, you are expected to actively participate to achieve your health goals. This includes commitment to your home exercise program.

Below is a list of the typical types of visits and the costs you can expect to encounter when visiting QuistMD:

Type of Visit	Estimated Price Range*
New Patient Visit with Dr. Haggquist	$455 - $565
New Patient Visit with Dr. Hines or Dr. McIlvaine	$425
Established Patient with Dr. Haggquist	$215 - $420
Established Patient with Dr. Hines or Dr. McIlivaine	$295-$325
Established Patient with Therapists Kevin Kenny or Andrea Morales	$220-$240
MRI Review with Dr. Haggquist	$125 - $195
Established Patient Visit with Therapist & Dr. Haggquist	$330-$345
Massage with Andrea Morales or Zelda Wafer-Jones	$160-$235
Letter of Medical Necessity	$75 - $150
Phone Consultation/Telehealth Visit	$140 - $295
Medical Records Request (By Patient)	$22.88 + $.65 per page

*Prices vary depending on types of procedures performed during visit

Registration

Date_____ First Name (Legal)_____ Last Name (Legal)_____ MI___
Preferred name or nickname (if applicable): _____
DOB_____ Current Age_____

Sex: Female Male
Gender identity: Female Male Other (Please specify pronouns if desired):

Primary Phone Number _____Email _____

Home Address _____
(Street) (City) (State) (Zip)

Occupation (if retired, previous occupation) _____ Employed By _____

Referred By_____ Relationship _____

Primary Care Physician _____
First and Last Name City, State

Insurance Subscriber _____
Name Relationship to Patient Date of Birth

Emergency Contact _____
Name Relationship to Patient Phone Number

Marital Status: _____ Spouse/partner name if applicable: _____

If minor, name of parent(s)/guardian(s): _____

Consent to Treat

I hereby authorize Dr. Jeffrey P. Haggquist and/or any of the therapists working in this clinic to treat with the Therapeutic Modalities prescribed by Dr. Jeffrey P. Haggquist. This consent does not expire and is valid until revoked in writing.

Such Therapeutic Modalities may include (but are not limited to):

Active Isolated Stretching ("AIS")
Active Isolated Strengthening
Neuromuscular Therapy ("NMT")
Massage
Ice massage
Deep Muscle Stimulation
Trager® massage
Therapeutic exercise

Possible risks associated with Therapeutic Modalities may include:

Temporary Dizziness
Muscle soreness
Nausea
Joint inflammation
Muscle / soft tissue tearing (if taking cholesterol reducing medication such as Lipitor or Zetia)

I am aware that there are certain risks associated with this treatment, and that the practice of medicine is not an exact science. I acknowledge that there are no guarantees concerning the results of the treatment or its interpretation. By signing below, I certify that I have read and understand the contents of this form.

Signature Date

IF THE PATIENT IS UNABLE TO CONSENT OR IS A MINOR: I acknowledge that the Patient is a minor, ___years of age, or otherwise unable to consent. Therefore, acting as the Patient's authorized representative, I consent to the treatment as described above. This permission includes occurrences when the patient is unaccompanied by a parent, guardian or authorized representative. This includes all medical treatment including assessment, diagnosis, treatment, and therapy. This consent will be valid until revoked in writing by me from the date signed unless otherwise specified in writing.

My child may be accompanied by the following persons other than myself, and I consent for the following individuals to join the patient in the room, hear health information presented, and depart the clinic with my child:

_____
Name and relationship to patient

_____
Name and relationship to patient

Parent/Guardian/Authorized Representative: _____
Name Relationship to Patient

Signature Date

MEDICARE OPT-OUT PATIENT CONTRACT (Opt-Out Period: 01/01/22 – 12/31/23)

MUST COMPLETE IF OVER THE AGE OF 63 OR ACCEPTING DISABILITY

QUISTMD STAFF: IF COMPLETED, PLACE IN FRONT OF SECTION:INSURANCE

This agreement is between Dr. Jeffrey P. Haggquist, DO PLLC ("Physician"), whose principal place of business is located at 5630 Connecticut Avenue NW Suite 2, Washington DC 20015, and patient _____("Patient"), who resides at _____ and is a current or future Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on January 1, 2008 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):
Physical Medicine and Rehabilitation Services including Flexibility and Strengthening Exercises.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:
Initial

____ Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.

____ Patient is not currently in an emergency or urgent health care situation.

____ Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.

____ Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.

___ Patient acknowledges that s/he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

____ Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

____ Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

____ Patient acknowledges that a copy of this contract has been made available to him/her.

____ Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____ by: _____ and Jeffrey P. Haggquist, DO
Date

_____ _____

Patient signature *Physician signature*

Medical Questionnaire: Please fill this portion out completely

Date _____Name _____ DOB_____ Age_____ Height _____ Weight _____

PRESENTING HEALTH PROBLEM(S)

_____
_____
_____

TREATMENTS & RESULTS

_____
_____
_____

HISTORY OF PRESENT ILLNESS: Briefly describe how and when the problems began and progressed

_____
_____
_____

HOSPITALIZATIONS DATE

_____
_____
_____

INJURIES (sprains, fractures, surgery, dislocations & scars) DATE

_____
_____
_____

CURRENT MEDICATIONS DOSE, FREQUENCY, & RESPONSE

- Blood thinners _____
- Narcotics & Pain Killers _____
- Muscle Relaxants _____
- Anti-seizure _____
- Statins _____
- Fluorquinolone Antibiotics: *Cipro, Levaquin, Floxin* _____
- Methyphenidate hydrochloride: *Ritalin* _____
- Fexofenadine: *Allegra* _____
- Proton Pump Inhibitors: *Nexium, Prilosec, etc.* _____
- Verapimil _____
- Erythromycin/ Clarithromycin _____
- Zelnorm _____
- **Any other medications/supplements**: _____

TESTS	DATE	RESULTS	TESTS	DATE	RESULTS
___ EEG			_____CT SCAN		
___ EKG			_____MRI		
___ EMG			_____Stress Test		
___ SCAN			_____ X-Rays		

FOOD ALLERGIES

_____ Milk Products
_____ Wheat/Grains
_____ Food dyes, Additives
_____ Nuts
_____ Others

DRUG ALLERGIES: List and describe reactions to drugs, medications or anesthetics or indicate no known drug allergies (NKDA) [ ]

_____
_____
_____

Name: _____ Date: _____

YOUR HISTORY Any of the following that you have ever had:

- Stroke
- Heart Disease
- Chest Pain
- Murmur/MVP
- Respiratory Problems
- Shortness of Breath
- Lyme Disease
- Neurological Problems
- Parkinsonism
- Tremor
- Epilepsy/Seizures
- Nerve Pain
- Where_____
- Paresthesias tingling sensation Where_____
- Numbness Where_____
- Bowel or Bladder Changes
- Weakness Where_____
- Headache/Migraine
- TMJ/Jaw Dysfunction
- Joint/Hip Instability
- Joint Cartilage Degeneration
- Chronic Joint Pain
- Recurrent Ankle Sprains
- Torn knee cartilage
- Bruising
- Fractures (any)
- Increased flexibility as a child
- Osteopenia or Osteoporosis
- Back Pain
- Scoliosis
- Muscle/Joint Pain and/or Stiffness
- Carpal Tunnel
- Autoimmune Disease
- Raynaud's Syndrome
- Flat Feet
- Plantar Fasciitis
- Bunion
- Arthritis
- Varicose Veins
- Hernia
- Uterine or Rectal Prolapse
- Leg Length Difference
- Pelvis Unlevel or Rotated
- Gout
- Anxiety
- Psychological problems
- Weight Change Gained_____ Lost_____ Over what time?_____

OR HAVE NOW:

- Thyroid Hypo Hyper
- Diabetes
- Eye Problems
- Digestive Disorders
- Abdominal Pain
- Vomiting
- Diarrhea
- Nausea
- Constipation
- Rashes
- Night Sweats
- Fever
- Chills
- Fatigue
- Candida
- Other

FAMILY HISTORY (any of which affected your parents, grandparents, siblings, or children):

CONDITION	Relative(s) Affected	CONDITION	Relative(s) Affected
Genetic Disease	_____	Scoliosis	_____
Allergies	_____	Gout	_____
Arthritis	_____	Headache/Migraine	_____
Heart Disease	_____	Bleeding Problems	_____
Overweight	_____	Depression	_____
Stroke	_____	Osteoarthritis	_____
Diabetes	_____	Thyroid Disease	_____
Digestive/GI	_____	Suicide/Suicidal	_____

ACTIVITY LEVEL

- SEDENTARY (inactive) by choice
- SEDENTARY (inactive) due to inability or restriction
- Light (light daily work and no regular exercise)
- Moderate (light daily work and exercise 3x a wk)
- Sustained (moderate daily work and exercise 5x a wk)
- Heavy (heavy work and heavy exercise 5x a wk)

STRESSORS Affecting Your Life

- Difficulties with work or lifestyle
- Illness-personal
- Other _____

ACTIVITY TYPE

Running/Jogging	Football
Swimming	Tennis
Soccer	Racquetball
Cycling	Hiking
Softball	Baseball
Basketball	Yoga
Weight lifting	Aerobics
Pilates	Other_____

NAME: DATE:

PAIN DRAWING

Please complete this chart so we can better understand the location and intensity of your pain

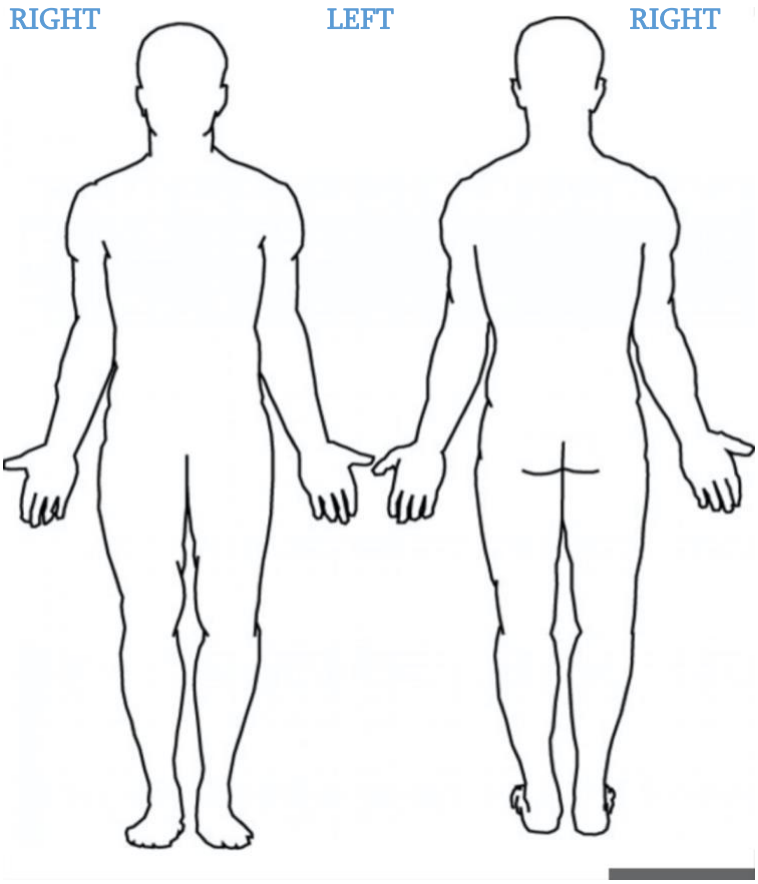
Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below

☐LEFT HANDED

☐RIGHT HANDED

KEY
////// STABBING
XXXX BURNING
0000 PINS AND NEEDLES
==== NUMBNESS

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it, but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

~~Returning patients only:~~

Are you taking any new medications?

[ ] NO [ ] YES, listed below:

_____

_____

_____

_____

_____

What makes this pain worse (e.g. sitting, running)?

_____

_____

_____

_____

_____

_____

What makes this pain better (e.g. medications, ice/heat)?

_____

_____

_____

_____

_____

_____

Adapted from the American Academy of Physical Medicine and Rehabilitation Patient Pain Drawing

QUISTMD

Name: _____ Date: _____

Important Insurance Information

Dr. Haggquist, D.O., PLLC, does not participate with any insurance companies and has opted-out of Medicare.

Fees

All charges are payable to Dr. Haggquist, D.O., PLLC, at the time services are rendered. At the end of your visit the office will provide a sales receipt upon request, which contains a record of your payment, procedure code(s) and diagnosis code(s).

Dr. Haggquist, D.O., PLLC, will electronically submit claims to your primary insurance company on your behalf. Secondary insurance is required to be submitted manually, and therefore will not be submitted by Dr. Haggquist, D.O., PLLC.

If enrolled in Medicare, you are responsible for submitting the opt-out form and HCFA form for each appointment directly to your secondary insurer. You may not submit to Medicare, as our office has opted out.

The treatment that Dr. Jeffrey P. Haggquist, D.O., PLLC, prescribes includes Active Isolated Stretching and Strengthening (AIS), a therapeutic exercise. Please be aware that although our services are a medical specialty (Physical Medicine & Rehabilitation), because of the dynamic nature of the healthcare industry, reimbursement by your health plan may take persistence and focus and is NOT guaranteed. Certain procedures require pre-authorization. Pre-authorization does not guarantee full payment. Please contact your insurance company prior to scheduling any therapy appointments.

I understand the policy regarding health insurance and the charges of Dr. Jeffrey P. Haggquist, D.O., PLLC, and The Flexibility, Sports & Rehabilitation Clinic. I assume all responsibility for all charges incurred during my visits. I also understand these charges will be paid at the time services are rendered. In addition, Jeffrey P. Haggquist, DO, PLLC, and The Flexibility, Sports & Rehabilitation Clinic will provide a sales receipt that details my charges, procedures and diagnoses at the end of each visit upon request.

Signature Date

Appointment cancellation policy

Dr. Haggquist and the therapists see one patient at a time, typically for a full hour or 90 minutes. Your appointment time is reserved exclusively for you. Appointments cancelled without 36 hours' notice will result in a cancellation charge of $75 the day before, or $150 if cancelled same-day. Future appointments will not be made until the cancellation charge has been paid in full. You may e-mail, call or leave a voicemail at the office at any time upon realizing that you will not be able to make your scheduled appointment.

I have read the above and understand my financial obligation.

Signature Date

Patient Name Date of birth

Authorization for Request for Release of Information to QuistMD

I authorize_____ to furnish information in its possession

(treating physician or other provider)

relative to my diagnosis, treatment or account status to Jeffrey P. Haggquist, DO PLLC/QuistMD, The Flexibility, Sports & Rehabilitation Clinic.

Signature (Patient/Client/Legal Guardian) Relationship Date Signed

Authorization for Release of Information from QuistMD

I authorize Jeffrey P. Haggquist, DO PLLC**/**The Flexibility, Sports & Rehabilitation Clinic to furnish information in its possession relative to my diagnosis, treatment or account status to:

Name (s) of authorized entities and individuals (may specify other treating physicians, healthcare providers or institutions, insurance provider (and/or their agents), and/or family members).

Signature (Patient/Client/Legal Guardian) Relationship Date Signed

RECORDS TO BE SENT TO (OPTIONAL):

Name:

Address:

Phone number:

Fax number:

Name:

Address:

Fax Number:

Fax Number:

EMAIL AUTHORIZATION (OPTIONAL):

I authorize communication of medical information via my email address: _____

Signature (Patient/Client/Legal Guardian) Relationship Date Signed