Cost per client formula:

1. Compute your office overhead for a month:

You can take the last 12 months and divide by 12. If you haven't been working for a year, you can estimate using numbers from the time you have worked.

	Sample	
Salary/needed income	$4000	
Rent	$600	
Other salaries		
Office expenses	$150	
Office Supplies	$50	
Marketing	$200	
Total Expenses per month	$5000	

2. Compute the number of patients for the month. You can use last years patients divided by 12 or estimate the number for this year.

Sample: 15 clients per week x 4.2 weeks/mo = 63 clients per month

3. Cost per patient = Total monthly expenses____ divided by Total monthly patient visits

Sample: $5,000 ÷ 63 = $79.00

This is what your cost per patient is.

4. Evaluate

If you expect the number of clients to go up per month by 21 (5 per week) your cost per client will go

down.

$5000 ÷ 84 =59.52

$59.52 will be your new cost per client.

What is the amount that the insurance company will be paying you?

Less than that or more than that?

Will it be worth it to take on new clients at that expected rate?

Will you get too many clients that you will have to hire office support to do the extra work involved?

Hiring someone will increase your expenses and increase the cost per client.

ICD 9 Codes

Numerical Listing of ICD 9 CM Codes

I am supplying a list of common codes listed by their code and not alphabetically. My purpose in doing this is to make it more difficult for you to determine a code (make a diagnosis) without a prescription. The referring physician must supply all diagnosis codes. If you determine a code yourself, you are practicing out of your scope of practice and may be found to be practicing illegally in your state. You may lose your license.

* **Sprain and Stain codes** require an extra digit. Use only the indented codes

** **Fifth digit instructions** will be found at the end of the section.

Sprain - a sprain involves some tearing of ligament tissue

Strain - a strain is the tearing of musculo-tendinous tissue

250	Diabetes
307.81	Tension headache, Tension
311	Depression
337.20	Reflex Sympathetic Dystrophy - unspecified
337.21	Reflex Sympathetic Dystrophy – upper limbs
337.22	Reflex Sympathetic Dystrophy – lower limbs
337.29	Reflex Sympathetic Dystrophy – Other specified site
340	Multiple sclerosis
344.0	Quadripelgia
344.1	Parapalegia
346.1	Migraine headache – common
345.9	Epilepsy
350.1	Trigeminal Neuralgia
351.0	Bell's Palsy
351.8	Facial neuralgia
351.0	Facial paralysis
353.0	Thoracic Outlet Syndrome
353.1	Lumbrosacral Plexus Lesion
353.4	Lumbrosacral Root Lesion
353.3	Thoracic Plexus Lesion
354.0	Carpal Tunnel Syndrome
356.9	Peripheral neuropathy (unspecified)
359.1	Muscular dystrophy
379.91	Pain in or around eye
381.4	Ottis Media, unspecified
381.6^	Obstruction/Eustachia

^Fifth digit

0 = Unspecified
1 = Osseous Obstruction
2 = Intrinsic Cartilaginous
3 = Extrinsic Cartilaginous

388.70	Earache
401.9	High blood pressure, hypertension
461.0	Maxillary sinusitis (acute)
461.1	Frontal sinusitis (acute)
461.2	Ethmoidal sinusitis (acute)
461.3	Sphenoidal sinusitis (acute)
472.0	Rhinitis, chronic
473.0	Maxillary sinusitis (chronic)
473.1	Frontal sinusitis (chronic)
473.2	Ethmoidal sinusitis (chronic)
473.3	Sphenoidal sinusitis (chronic)
480	Pneumonia
493.0	Asthma, allergic
493.9	Asthma, bronchial
524.60	Temporomandibular joint disorder (arthralgia/pain)
625.2	Hot flashes
625.3	Menstrual pain, dysmenorrhea
714.0	Rheumatoid arthritis
715.05	Osteoarthritis, Pelvis
716.9**	Arthritis (Arthropathies)
716.95	Inflammation of Pelvis
718.0	Meniscus Tear, chronic
718.50	Ankylosis
718.51	Ankylosis, shoulder
718.52	Ankylosis, upper arm
718.53	Ankylosis, forearm
718.54	Ankylosis, hand
718.55	Ankylosis, lower leg

718.56	Ankylosis, ankle, foot
719.0	Joint Swelling
719.4	Pain in the joint
719.5**	Stiffness of joint
720.0	Ankylosing Spondylitis
720.2	Sacrolitis
720.9	spondylitis, thoracic
721.9	Arthritis, degenerative, hypertrophic
722.2	IVD prolapse, protrusion, herniation, rupture
722.4	Cervical Disc degeneration
722.51	Thoracic Disc degeneration
722.52	Lumbar Disc Degeneration
723.0	Spinal stenosis, cervical region
723.1	Cervicalgia (pain in neck)
723.2	Cervicocranial Syndrome, upper neck pain
723.3	Cervicobrachial Syndrome
723.4	Cervical radiculitis, brachial neuralgia
723.5	Stiff neck torticollis (contracture of neck)
723.9	Unspecified musculoskeletal disorders and symptoms referable to the neck
724.02	Lumbar stenosis
724.1	Pain in Thoracic Spine
724.2	Low back pain (Lumbago)
724.3	Sciatica
724.4	Radiculitis
724.5	Backache, unspecified, postural
724.6	Disorders of Sacrum, ankylosis of sacrum
724.8	Back stiffness, facet syndrome
726.0	Frozen shoulder
726.10	Rotator cuff syndrome of shoulder - unspecified
726.32	Lateral epicondylitis (Tennis elbow, Golfer's elbow)
726.90	Tendinitis
728.2	Muscular wasting or atrophy
728.4	Laxity of Ligaments
728.5	Hypermobility Syndrome
728.85	Muscle Spasms
728.9	Weak muscle
729.1	Myalgia and Myositis unspecified;
729.2	Radiculapathy (nerve compression)
729.5	Pain in limb(sore arms/wrist/leg/sole of foot)
733.00	osteoporosis
733.90	Pain in bone - Unspecified
736.81	Short leg – Acquired
737.2	Lordosis, acquired, postural
737.9	Curvature of the spine, acquired
738.2	Acquired Deformity of Neck
738.6	Acquired deformity of the pelvis
739.1	Segmental dysfunction, cervical
739.2	Segmental dysfunction, thoracic
739.3	Segmental dysfunction, lumbar
739.4	Segmental dysfunction, sacrum
739.5	Segmental dysfunction, Pelvis
739.9	Curvature, acquired
741.1	Spina bifida, cervical
741.2	Spinabifida, thoracid
741.3	Spinabifida, lumbar
754.2	Scoliosis, congenital
755.30	Short leg, congenital
756.13	Absence of vertebrae, congenital
756.15	Fusion of spine, congenital
756.2	Cervical Rib
780.4	Dizziness, Vertigo
780.50	Sleep disturbance
780.7	Fatigue
781.2	Abnormality of gait
782.0	Sensitive skin
782.3	Edema
784.0	Headache, facial pain (vascular)
786.51	Midsternal Chest Pain
786.52	Painful Respiration
786.59	Musculoskeletal Chest Pain
787.1	Heartburn
840.*	Sprains and strains of shoulder and upper arm
840.0	Acromioclavicular (joint) (ligament)
840.1	Coracoclavicular
840.2	Coracohumeral (muscle) (ligament)
840.3	Infraspinatus (muscle) (tendon)
840.4	Rotator Cuff (capsule)
840.5	Subscapularis (muscle)
840.8	Other specified sites of shoulder and upper arm
840.9	Unspecified site of shoulder and upper arm
841.*	Sprains and strains of elbow and forearm
841.0	Radial collateral ligament
841.1	Ulnar collateral ligament
841.2	Radiohumeral (joint)
841.3	Ulnohumeral (joint)
841.8	Other specified sites of elbow and forearm
841.9	Unspecified site of elbow and forearm
842.0*	Sprains and strains of the wrist

842.0 Unspecified site
842.1 Carpal (joint)
842.2 Radiocarpal (joint) (ligament)
842.9 Other - Radioulnar joint, distal
842.1* Sprains and strains of the hand
842.10 Unspecified site
842.11 Carpometacarpal (joint)
842.12 Metacarpophalangeal (joint)
842.13 Interphalangeal (joint)
842.19 Other - Midcarpal (joint)
843.* Sprains /strains of hip and thigh
843.0 Iliofemoral(ligament)
843.1 Ischiocapsular (ligament)
843.8 Other specified sites, hip/thigh
843.9 Unspecified site of hip and thigh
844.* Sprains/strains of knee and leg
844.0 Lateral collateral ligament: knee
844.1 Medial collateral ligament, knee
844.2 Cruciate ligament of knee
844.3 Tibiofibular (joint) (ligament), superior
844.8 Other specified sites of knee/leg
844.9 Unspecified site of knee and leg
845.0* Sprains and strains of ankle
845.00 Unspecified site
845.01 Deltoid (ligament), ankle
845.02 Calcaneofibular (ligament)
845.03 Tibiofibular (ligament), distal
845.09 Other
845.1* Sprains and strains of foot
845.10 Unspecified site
845.11 Tarsometatarsal (joint) (ligament)
845.12 Metatarsophalangeal (joint)
845.13 Interphalangeal (joint), toe
845.19 Other
846.* Sprains/strains of sacroiliac
846.0 Lumbosacral (joint) (ligament)
846.1 Sacroiliac ligament
846.2 Sacrospinatus (ligament)
846.3 Sacrotuberous (ligament)
846.8 Other specified sites of sacroiliac region

846.9 unspecified site of sacroiliac region
847.* Sprains/strains of other and unspecified parts of back
847.0 Neck: Anterior longitudinal (ligament), cervical Atlanto-axial (joints) Atlanto-occipital (joints) Whiplash injury
847.1 Thoracic
847.2 Lumbar
847.3 Sacrum
847.4 Coccyx
847.9 Unspecified site of back
848* Other and ill defined sprains and strains
848.0 Septal cartilage of nose
848.1 Jaw
848.2 Thyroid region
848.3 Ribs
848.5 Pelvis
848.8 Other specified sites of sprains/strains
848.9 Unspecified site of sprain/srain
848.4* Sternum
848.40 Unspecified site
848.41 Sternoclavicular (joint) (ligament)
848.42 Chondrosternal (joint)
848.49 Other - Xiphoid cartilage

****** **Fifth Digit Instructions**

If the place for the fifth digit of a code has a space with a double asterisk (**) in it, refer back to this page for the selection of the appropriate fifth digit.

0 Site unspecified	**5** Pelvic region & thigh
1 Shoulder region	**6** Lower Leg
2 Upper arm	**7** Ankle and foot
3 Forearm	**8** Other specified sites
4 Hand	**9** Multiple sites

The use of 0, 8 or 9 may require further documentation.

Insurance Benefits Verification Form

Patient Name _____

Address_____

Social Security #_____date of birth_____

Work phone_____ home phone_____

Referring Physician_____

Insurance Information:

Insured's name:_____

Insured's Date of Birth:_____ Insured's SS#_____

Address:_____

Work phone: _____home phone_____

Social security number_____

Claim number or ID number_____

Group number_____

Allowable benefits:_____

Yearly deductible :_____ Has it been met?_____

Co-pay_____

Name of person you talked to at your insurance company_____

Date and time of conversation:_____

Follow up/ comments

_____

_____

_____

Track communications with the insurance company

Patient :_____

Patient ID number/claim number_____

Issue_____

_____

Resolution:_____

What the insurance company will do:

_____

_____

What you need to do:

_____

_____

Follow up scheduled for: _____

Person you spoke with:_____

Date and time you spoke with person:_____

Notes:

Confidential Health Intake Form

Name _____Date of Birth _____
Street Address _____
City_____State_____Zip_____
Wk. Phone _____Hm.phone_____CellPhone_____
Emergency Contact _____
Employer _____ Social Security Number _____
Occupation/employer _____
Referring Physician:_____Primary Care Physician:_____
Was Injury a result of an accident?_____ If yes: Job related_____Auto _____ Other_____
Date of Injury or onset: _____
Insurance Company
Name:_____
Billing Address:_____
Phone Number:_____
Contact person/ case manager _____
Name of Insured :_____Insured's date of birth_____
Address:_____
Phone:_____
Group/Claim Number/Id number:_____Insured'sss#_____
Attorney (if applicable) Name **:**_____
Address:_____
Phone number: _____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee. (Please note that insurance companies **do not** pay this, you do.)

Signature _____ Date _____

Medical History and Information

Check any or all that apply to your present health:

___ headaches	___chronic pain	___varicose veins
___ vision problems	___muscle or joint pain	___blood clots
___ sinus problems	___numbness/tingling	___high/low blood pressure
___ jaw pain/teeth grinding	___sprains/strains	___diabetes
___ fatigue	___scoliosis	___cancer/tumors
___ depression	___arthritis	___infectious disease
___ sleep difficulties	___tendonitis	___skin problems

Women only: ___Pregnant___ Painful menstruation___ endometriosis

Men only: ___Prostrate problems

List all medications/herbs/vitamins and dosage: _____

_____

List physical activities you participate in regularly

_____

_____

_____

What movements or activities are limited? _____

Describe the events of the injury or accident: _____

List previous major injuries/surgeries: _____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic): _____

What seems to help the most? _____

What seems to aggravate the condition the most?_____

What is your main activity at work? On phone _____Sitting_____ Computer work_____

Driving car_____Walking_____ Other _____

What do you do to relieve stress?_____

What do you want to get out of you session (s)?

_____

_____

Confidential Client Intake Form

Last Name(2)_____First Name_____MI____

Address (5) _____

City _____State _____Zip _____

SS# _____ _____ _____ Birthday (3)___/___/___ Circle: M F

Home Phone _____Office Phone _____

Referred By (17) _____Dr. Phone_____

Emergency Contact Name _____Phone Number _____

Status (8) Single _____ Married _____ Other _____ Employed _____ Full-Time Student _____ Part-Time Student _____

Condition Related to (10)a. Employment (Y) (N) b. Auto Accident (Y) (N) c. Other accident (Y) (N)

Insured's I.D. (if different from client) # (1a) _____ _____

Insured's Name (4) Last _____ First _____ M.I. _____

Address (7) _____City _____State _____ Zip _____

Insured's Policy or Group Number (11) _____ Insured's D.O.B. (a) _____/_____/_____

Employer's Name (b) _____

Insurance Plan Name (c) _____

Is there another health benefit plan? (d) Y ___ N ___ (If yes, fill out below)

Other insured's name (9) Last _____ First _____ MI ___

Other Insured's policy or group # (a) _____ D.O.B. (b) _____/_____/_____ Sex: M ___ F ___

Employer's Name (c) _____Insurance Plan Name (d) _____

The responsibility for the cost for each massage therapy session is the client's. Whatever portion of the session(s) not covered by a third party payer is the client's responsibility. Release (12) : Authorized signature: I authorize the release of any medical or other information necessary to the medical treatment of my condition and to process this claim. I also request payment of medical benefits either to myself or to this medical provider.

Signature_____ Date _____

Physician Diagnosis(21)_____ ICD 9 _____

Physicians Referral for Massage Therapy Services

From:_____ Patient Name:_____ Address:_____ _____ SS#_____ Date of Birth:_____ Insurance Company:_____ Policy Number:_____ Claim Number:_____ Billing Address:_____ Date of Injury:_____ Diagnosis/ICD-9 code(s):_____ _____ _____ _____ _____	Condition is related to ___MVA___work injury ___Other injury ___Stress ___other medical condition Number of sessions to be done: (frequency and duration)_____ _____ Send progress report: ____ every week ____every two weeks ____at the completion of prescribed treatments ____other_____ Special directions/Comments:_____ _____ Areas to be worked on: (circle all that apply, add comments)

Cranial: Temporalis, Masseter, Frontalis_____
_____
Cervical: E.S, Levator, Scalenes, SCM, Spenius Cervicus/Capitis, Trapezius, Sub-occipitals_____
_____
Thoracic: E.S, Rhomboid, Serratus Anterior, Trapezius, Serratus posterior superior_____
_____
Shoulder: Infraspinatus, Supraspinatus, Subscapularis, Teres , Deltoid, PecMj, PecMn_____
_____
Lumbar: E.S, Quadratus, Iliacus, Psoas_____
Sacral: Gluteus Max, Min, Med, Rotators, IT Band, Quads, Hamstrings, TFL_____
_____
Other:_____
Hydrotherapy: None, Heat, Cold Location:_____

Physicians Signature_____Date:_____
Physicians Name printed:_____
Address_____
Phone_____

Insurance Billing and payment Tracking

Billing Date	Ins. Co.	Dates of service	Co-pay	Amount billed	Amount paid	Payment date

Progress Report From:_____

To:_____

Progress Report as of:___/___/___

Regarding:_____

Treatments since last report:_____

Current Rx expires:_____

Overall Patient Progress is: ___Poor ___Marginal ___Good ___Excellent

Areas Treated: ___Cervical ___Thoracic ___Lumbar ___Sacral ___Other _____

Subjective and Objective Observations

	Left	**Right**	**No Current** Problem	**Improving**	**Not Improving**	**Increased** Symptoms
Neck						
Shoulder						
Arm						
Mid Back						
Low Back						
Pelvis						
Leg						

Patient rates their stress level as: ___Low ___Moderate ___High

OtherConcerns/Comments:

_____

_____

Thank You Very Much for your referral.