BODY REFORM
integrated physical therapies

PATIENT INFORMATION

Patient's Name:_____ D.O.B:_____ Date of 1st visit _____

Address: _____ Apt. #:_____

City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ Fax #: _____

Email: _____ Employed by: _____

Best way to contact you: _____

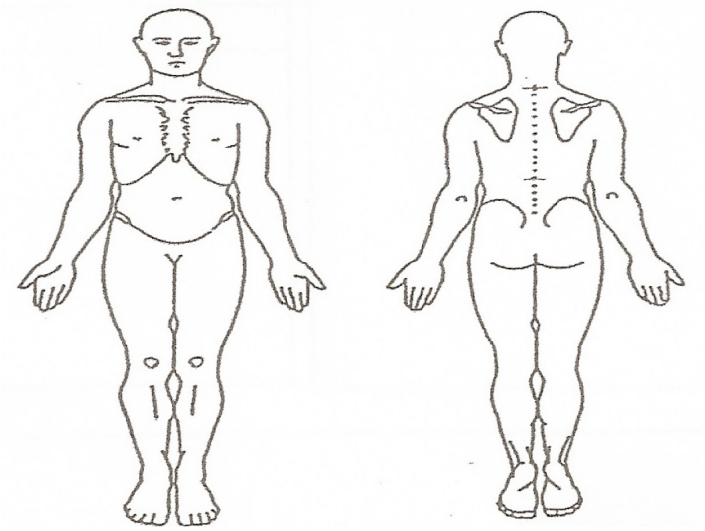
Emergency contact- Name/Relationship:_____ Phone #:_____

Referring Physician: _____ Phone #:_____

Referred by: _____

Reason(s) for visit. Please list them in order of importance.

Circle affected area(s):



Patient History

Name:_____ Birth Date:_____

Have you ever had:			(If yes, please explain)
Diabetes	Yes	No	_____
Cancer	Yes	No	_____
Osteoporosis/Osteopenia	Yes	No	_____
Pacemaker or similar device	Yes	No	_____
High Blood Pressure	Yes	No	_____
Heart or Circulation Disorders	Yes	No	_____
Immune Deficiency Disease	Yes	No	_____
Seizures	Yes	No	_____
Dizzy Spells	Yes	No	_____
Rheumatoid Arthritis	Yes	No	_____
Neurological Conditions	Yes	No	_____

What are your current symptoms?_____

_____

_____

What activities make your symptoms worse (i.e. sitting, standing, lifting)? _____

_____

_____

What activities make your symptoms better? _____

_____

_____

Date of Injury/Onset/: _____

Have you had prior treatment for your current condition (injections, physical therapy, chiropractic, acupuncture, massage, etc.)? If so, what type(s).____

_____

_____

Please list recent diagnostic studies (MRI, X-Ray, Cat-Scan):_____

_____

Please list surgeries you have had and approximate dates._____

_____

_____

Do you have any metal anywhere in your body; Pins/plates, or pacemaker? If yes, describe. _____

_____

Are you pregnant or trying to become pregnant? Yes No

Have you ever taken steroids or anti-coagulants for an extended period of time? Yes No

Have you had an unexplained weight gain or loss recently? Yes No

List medications you are now taking._____

_____

Financial Responsibility and Consent Form

Consent and Care for Treatment

I, the undersigned, hereby agree and give my consent for Body Reform Physical Therapies, Inc. to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of Body Reform Physical Therapies, Inc. to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photocopy of this authorization shall be as valid as an original.

Financial Responsibility

1. Payment in full is due at the time of service. We will keep a credit card on file for your convenience.
2. We are not a Medicare provider. We will not bill Medicare on your behalf, nor can you appeal to Medicare for Reimbursement.
3. We do not bill insurance. You may receive a detailed receipt (Superbill) for your records to submit to your insurance company. Regardless of the level of reimbursement from your insurance company, you are financially responsible for all services rendered by Body Reform Physical Therapies, Inc. You may wish to contact your insurance company directly should you have any concerns regarding insurance coverage for medical services rendered by an out-of-network provider. We will be happy to provide you a pro-forma Superbill if necessary.

Cancellation Policy

To better serve all patients, our office requires at least one business day's notice (at least 24 hours, exclusive of weekends and holidays) to cancel any office visit. Your credit card on file will be charged at regular rates for missed appointments. Cancellations must be made either in person, over the phone or via e-mail.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date

_____

Print Name

Medicare Non-Coverage Advance Notice

Dear Valued Patient:

We would like to inform you that the Bowstring Method©, created and practiced by physical therapist Shannon Harris, is not covered by Medicare, and Body Reform is not a Medicare provider. You will be responsible at the time of service for full payment. We will not bill Medicare on your behalf, nor can you appeal to Medicare for reimbursement.

The estimated cost of service is $150 for a half-hour, and $300 for an hour.

If this policy doesn't work for you, we will be happy to refer you to a quality clinic that provides services covered by Medicare.

Patient Signature _____

Date_____

Copy given to patient yes no

PATIENT INFORMATION ACKNOWLEDGMENT FORM

I have read and fully understand **Body Reform Physical Therapies, Inc's** Notice of Information Practices. I understand that **Body Reform Physical Therapies, Inc**. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Body Reform Physical Therapies, Inc**. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Body Reform Physical Therapies, Inc.'s** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

Body Reform Physical Therapies, Inc.
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Body Reform Physical Therapies, Inc. 's ***LEGAL DUTY***

Body Reform Physical Therapies, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Body Reform Physical Therapies, Inc. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ***Body Reform Physical Therapies, Inc.*** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Body Reform Physical Therapies, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, ***Body Reform Physical Therapies, Inc.*** s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Body Reform Physical Therapies, Inc. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ***Body Reform Physical Therapies, Inc.*** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ***Body Reform Physical Therapies, Inc.*** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ***Body Reform Physical Therapies, Inc. 's*** health information practices or if you have a complaint, please contact the following person: