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: _____

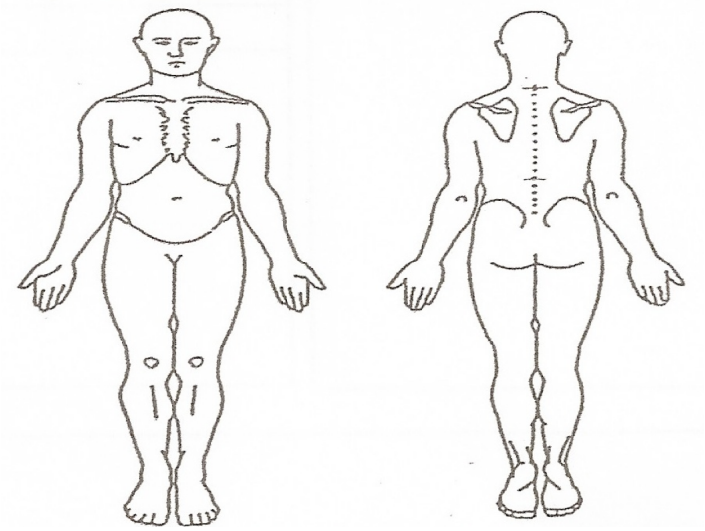
Emergency contact- Name/Relationship:_____ Phone #:_____

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)
Neurological or Neuro-Muscular conditions	Yes	No	
Rheumatoid Arthritis	Yes	No	
Osteoporosis/Osteopenia	Yes	No	
Seizures or Dizzy Spells	Yes	No	
High Blood Pressure	Yes	No	
Heart or Circulation Disorders	Yes	No	
Diabetes	Yes	No	
Pacemaker or similar device	Yes	No	
Cancer	Yes	No	
Immune Deficiency Disease	Yes	No	
Other (please explain)	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._____

_____

Please list any conditions that we should know about:_____

_____

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

Financial Responsibility

1. Payment in full is due at the time of service. If you would like, we could keep a credit card on file for your convenience. The in-office hourly rates for Body Reform therapists are: Shannon Harris $350. Mary Harris $125. Amanda VanDyk $250. Alexander Czubakowski $250. Mychal Prieto $125. (Please note that rates will be higher for any weekend and after-hour appointments).
2. We are not a Medicare provider. We will not bill Medicare on your behalf, nor can you appeal to Medicare for Reimbursement. This applies whether or not Medicare is your primary or secondary insurance.
3. We do not bill insurance on your behalf, although we'd be happy to give you a detailed receipt (Superbill) for you 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 can provide you a pro-forma Superbill if necessary. Please note that we do NOT give Superbills to Medicare age clients, regardless if you use Medicare or not.

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.

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.

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.

Please note that if you have insurance other then Medicare and you are of Medicare age, you will NOT be allowed to ask for a superbill.

The estimated cost of service is $350 for an hour. (Please note that rates will be higher for any weekend and after-hour appointments).

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

MEDICARE-Eligible Clients

Letter of Understanding

Body Reform is **not** contracted with Medicare or any other form of health insurance. **Services rendered in our practice are not covered by Medicare or your Secondary Insurance.**

If you would like Physical Therapy to be covered by Medicare or secondary insurance, we will be happy to provide you with alternative therapy options.

If you still want to be seen by Shannon Harris, MPT and/or Amanda VanDyk, DPT and/or Alexander Czubakowski, DC for his/her expertise in the Bowstring Method of bodywork, we ask that you sign below to indicate that you understand that this is a non-covered service by Medicare and to understand that **you cannot receive reimbursement** from your insurance provider, secondary or otherwise, for this service. You will not be allowed to ask for a superbill.

Because physical therapy has not yet been included in Medicare "opt out" legislation, Shannon Harris, MPT and Amanda Van Dyk, DPT and Alexander Czubakowski, DC do not treat Medicare-eligible clients for acute problems, post surgical treatment or any issues that are considered 'covered services.'

We would be happy to answer any questions you have regarding this matter.
Thank you for understanding.

_____ (initial here) I understand the Medicare-eligibility issue described above and I am willing to pay privately to see Shannon Harris MPT and/or Amanda Van Dyk DPT and/or Alexander Czubakowski DC (Body Reform Physical Therapies) for bodywork or massage therapy, wellness, prevention and fitness services.

_____ (initial here) I understand that neither I (the patient) nor Body Reform Physical Therapies (the provider,) will send any claims to any 3rd party payer, including Medicare, your secondary or supplemental insurance plans. I (the patient) will not allow anyone else, including my spouse, family members or agent, to send self-claims on my behalf.

_____ (initial here) I understand that I cannot ask and will not ask for a superbill for services rendered.

By signing below I acknowledge, under my own free will and accord, that I would like to restrict disclosure to my health plan by Body Reform for the purposes of payment, because I accept full out of pocket financial responsibility.

Signed: _____ Date:_____

Print Name: _____ Date of Birth:_____

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: