WholeBody
PHYSICAL THERAPY-RUNNING-WELLNESS

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information.

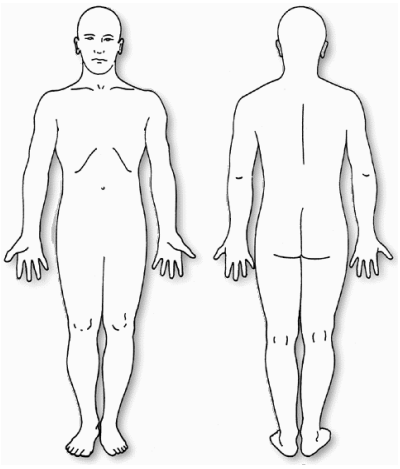
Name:	Last Name	First Name		Today's date:					
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit fax/phone number						
Specialist Physician	Name:		Date of next visit fax/phone number						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please shade in areas where you have pain, discomfort, or tension.



Please rate your pain in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.		
	At its worst	
	At its best	
	At present	
	Night (sleeping)	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No

Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?				Yes	No
Please Describe:					
In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).
If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

I walk for		**minutes before needing to rest**		
I stand for		**minutes before needing to sit**		
I sit for		**minutes before needing to change positions/get up**		
Do you have trouble getting up from a chair?			Yes	No
Do you have trouble putting on your shoes and socks?			Yes	No
Do you have difficulty climbing stairs?			Yes	No

Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

Informed Consent

I understand that WholeBody, PLLC will maintain my privacy to the highest standards and 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.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.

I understand that per IL direct access laws, my physical therapist must notify my physician of my plan of care and I consent to the release of my records to my doctor.

I also consent to WholeBody, PLLC communicating with me via text and email with my protected health information for the purpose of providing better care. I understand that while WholeBody, PLLC takes every precaution to protect my information, there is still a risk of my information being misdirected or intercepted.

I do hereby agree and give my consent for WholeBody, PLLC to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:_____

Date:_____

WholeBody, PLLC

HIPAA CONSENT FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO OUR PATIENTS:

Patient information will be maintained by WholeBody as described by the Notice of Privacy Practices contained in the Corporate Compliance Program and in compliance with federal and state regulation. You may obtain a copy of the Notice of Privacy Practices by contacting the Office Manager.

WholeBody reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. Per Illinois law, we will release your information to your physician. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. We will release information related to any work related injury to your employer. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy.

We reserve the right to:

- Call/text you to remind you of your next appointment and/or leave information on your voicemail.

  At what number(s) would you like to be contacted? _____-_____-_____

If we cannot contact you at the above number(s), numbers from the information sheet will be used.

If there is anyone that you would like us to share your health information with, please list the names below:

_____

I have read and understand my rights.

_____ _____ _____
Signature of patient or legal guardian Date Signature of WholeBody witness

_____ _____
Print the name of the patient DOB

NOTICE OF PRIVACY PRACTICES (MEDICAL)

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. We may use and disclosed your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
Payment means such activities as obtained reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 14th, 2003** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.
WholeBody, PLLC
406 W. US Highway 40
Troy, IL 62294
618-967-5539

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

_____
Patient's Signature

_____
Patient's Full Name

_____
Date

Telehealth/E-Visit Consent for treatment:

I understand that telehealth/E-visits do not have a hands on component.
Telehealth: I consent to video chat. I understand that no video will be stored.
E-Visit: I consent to the electronic exchange of information via email, text, etc.

I understand that technology has the potential to fail. I do not hold Whole Body, LLC at fault if information is lost due to technology malfunction.
I understand that text or Facebook is not a secure way to exchange information.

_____

Patient signature Date

Cancellation and No Show Policy

All cancellations need to be made 24 hours prior to your appointment.
If you do not show up for your appointment or cancel within 24 hours, you will be responsible to pay for 100% of the session.

Payment Policy

Payment, in the form of cash, check or credit card, is due at the time of each visit.

We are not contracted with any insurance companies. However, the payments you make may be reimbursable by your insurance company under your out of network physical therapy benefits; the exact percentage depends upon your plan. Due to the complex nature of insurance claims and reimbursement, I make no promises as to whether you will receive reimbursement.

We will assist you in every way possible. Payment is due at the time of service.

I have read and understand the above policies:

Name_____

Signature_____

Date_____

Thank you for your cooperation and business.
Whole Body, LLC

WholeBody

PHYSICAL THERAPY-RUNNING-WELLNESS

Participation Agreement, Release, and Acknowledgement of Risk

WholeBody is a holistic wellness office that offers physical therapy services, wellness services, and coaching services. Our name, meaning "unbroken," represents our belief that the key to living a life free of pain and limitations starts by addressing the body as a whole.

Informed Consent For Physical Therapy Services

What Is Included in Physical Therapy Services? *Physical therapy services include: (a) the examination, evaluation, and testing of individuals to diagnose mechanical, physiological, or developmental impairment, functional limitation, disability or other health and/or movement disorders, to determine a rehabilitation prognosis and plan of therapeutic intervention, and to assess the ongoing effects of the interventions; (b) the alleviation of impairments, functional limitations, and/or disabilities by designing, implementing and modifying therapeutic interventions; and (c) the reduction of the risk of injury, impairment, functional limitation, and/or disability.*

What Are Examples Of Therapeutic Interventions? *Therapeutic interventions may include, but are not limited to: the evaluation or treatment of a person through the use of the effective properties of physical measures and heat, cold, electricity and use of therapeutic massage, therapeutic exercise, mobilization, and rehabilitative procedures, with or without assistive devices.*

Why Is My Physical Therapist Promoting Various Fitness, Health And Wellness Plans? *In providing a comprehensive physical therapy evaluation, a physical therapist may promote various fitness, health and wellness plans (including wellness and coaching services offered by WholeBody) designed to reduce an individual's risk of injury, impairment, functional limitation and/or disability. These recommendations are not considered treatment.*

Which Services Are NOT A Part of Physical Therapy Services? *Physical therapy does not include wellness services (see below), coaching services (see below), radiology, electrosurgery, chiropractic technique or determination of a differential diagnosis.*

What are Your Potential Risks from Physical Therapy Services? *You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, you agree to contact your physical therapist.*

Informed Consent For Wellness Services

What is the function of Wellness Services? *Wellness services are non-invasive physical touch services used to increase flexibility and mobility and to reduce muscle tightness, tension and discomfort.*

What is NOT Included in Wellness Services? *These services do not include diagnostic services, specifically, the examination, evaluation, and testing of individuals to diagnose mechanical, physiological, or developmental impairment, functional limitation, disability or other health and/or movement disorders, to determine a rehabilitation prognosis and plan of therapeutic intervention, and to assess the ongoing effects of the interventions.*

What are examples of Wellness Services?

Myofascial Release - During myofascial release therapy, the provider locates myofascial areas that feel stiff and fixed instead of elastic and movable under light manual pressure. These areas, though not always near what feels like the source of pain, are thought to restrict muscle and joint movements, which contributes to widespread muscle pain. The focused manual pressure and stretching used in myofascial release therapy loosen up restricted movement, leading indirectly to reduced pain.

Therapeutic Stretching - Therapeutic Stretching is similar to massage in that it is delivered one-on-one and on a table. Before there treatment begins, you will complete a health intake form and do a short assessment with your provider. The provider will then focus on movements that target the muscles and connective tissue that surround the joints. The provider will move your body for you into postures that stretch specific muscle groups. To increase the effectiveness of some stretches, comfortable straps may be used. Your goal during the session is to relax, breathe and let the stretch therapist take the weight of your limbs and move you through the stretches. You should feel a stretch sensation, but never pain.

What are Your Potential Risks from Wellness Services? *You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. Some clients have reported sensations (electrical, tugging, burning), muscle twitching, fatigue, delayed soreness, migration of pain, dizziness, nausea, and headaches/migraines following myofascial release, Any pain or discomfort is usually temporary; if it does not subside in 24 hours, you agree to contact your provider.*

Informed Consent For Coaching Services

What is included in Coaching Services? *Coaching services include group physical training courses and educational courses to teach skills focused on holistic wellness.*

What courses do you offer? *Currently, WholeBody offers senior exercise sessions, yoga, bike fittings, and plant based nutrition coaching.*

Are only group courses offered? *No. These services may be provided to you individually subject to the availability of the course instructor. Pricing for individual classes are determined by the instructor.*

What are Your Potential Risks from physical training classes? *Group physical training and exercises entail known and unanticipated risks which could result in physical or emotional injury, paralysis, death or physical damage to myself, to property or to third parties. The risks, include, among other things: collision with other participants, the equipment, the walls or other fixed objects, falling down, equipment failure, my own or other's negligence, objects or conditions on the surfaces that cause me to fall.*

ACKNOWLEDGMENTS

My initials next to each line below will serve to show that I acknowledge each statement and agree to the terms of this Participation Agreement, Release and Acknowledgement of Risk.

_____ **I have read this Consent to Treat carefully and completely.**

_____ **I understand what is included in physical therapy services, wellness services and coaching services, and that my medical physician may or may not agree with the necessity for or interpretation of the recommended treatments.**

_____ **I have had an opportunity to ask questions and obtain any desired clarification.**

_____ **I also understand that there is no guarantee or warranty for a specific cure or result.**

_____ **I understand the above statements regarding examination and treatment side effects.**

_____ **I give my permission and consent to WholeBody to perform physical therapy services, upon my request, including the performance of assessments and treatments as recommended by WholeBody from time to time.**

_____ **I understand that I can stop the services at any time.**

_____ **I voluntarily release, forever discharge and agree to indemnify and hold harmless WholeBody from any and all claims, demands, or causes of action, which are in any way connected with my participation in physical therapy services, wellness services, or coaching services or my use of WholeBody's equipment or facilities, including such claims which allege negligent acts or omissions of WholeBody.**

_____ **I agree that should WholeBody or anyone acting on its behalf, be required to incur attorney's fees and costs to enforce this Agreement, I agree to indemnify and hold them harmless for such fees and costs.**

Today's Date:

_____

By my signature below (including my typed signature via electronic submission) I voluntarily consent and agree to be bound to the terms of this Participation Agreement, Release and Acknowledgement of Risk.

Signature of Participant: _____

Printed Name of Participant: _____

Address: _____

Phone Number: _____

Email Address: _____