BODYWISE
PHYSICAL THERAPY

Patient History Form

Name:________________________ Date of Birth:________________

Have you recently noticed any of the following symptoms? Check all that apply.

- ☐ Change in bowel/bladder function
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance while walking
- ☐ Changes in appetite
- ☐ Fevers/chills/sweats
- ☐ Weakness/fatigue
- ☐ Difficulty swallowing
- ☐ Weight loss/ gain
- ☐ Headaches
- ☐ Feeling depressed
- ☐ Extreme anxiety

Have you ever been diagnosed with any of the following conditions? Check all that apply.

- ☐ Cancer (type?)________________
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Asthma
- ☐ Diabetes
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Kidney/liver problems
- ☐ Pacemaker inserted
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Other________________
- ☐ Anemia
- ☐ Lung problems
- ☐ Thyroid problems
- ☐ Epilepsy
- ☐ Stomach ulcers
- ☐ Rheumatoid arthritis
- ☐ Other______________

Please list any medications you are currently taking (including any blood thinners/anticoagulants):

____

____

Please list any allergies: **Are you latex sensitive? YES/NO**

____

____

Do you smoke? YES/NO **If yes, how many packs per day?** ____________ **Are you currently pregnant? YES/NO**

Please list any past surgeries or hospitalizations (including dates):

____

What is your main complaint? ________________________ **When did your symptoms start?** ____________________

What are your symptoms? ____________________________ **What makes it worse?** ________________________

What makes it better? ______________________________ **Are there any activities you are unable to do?** ____________

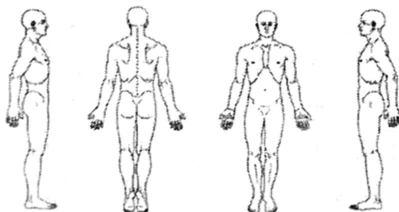
Have you been treated for this issue before? Where/When? ____

Describe your pain (dull, achy, sharp, constant, intermittent, only with certain movements, etc.):

____

What are your physical therapy goals? ____

On a scale from 0 to 10, how would you rate your pain? (0 - no pain, 10 - worst pain ever) please circle: 0 1 2 3 4 5 6 7 8 9 10



Body Chart: using the key below, please mark the location of your pain and type of pain:
X sharp stabbing pain
O dull achy pain
.... numb/tingling
/// throbbing
=== burning

Patient Signature: ______________________________ **Date:** ____________________

4440 Arapahoe Ave, Ste 101, Boulder, CO 80303
Phone: (303) 444-2529 Fax: (303) 444-2563 www.bodywisept.com

Patient Financial Agreement

Bodywise Physical Therapy is committed to serving our patients with professionalism and courtesy, and we expect the same from our patients. This includes being on time for your appointment and calling to cancel your appointment if you cannot make it. It also includes financial responsibility such as making your copayment or deductible payments at the time of your office visit. We accept cash, check, and all major credit cards.

Our practice accepts insurance from most major insurance companies. As a courtesy, we will verify and review you insurance coverage benefits, estimate your insurance payments, and the approximate amount of patient responsibility. Though the patient is liable for any costs not covered under his/her insurance plan, we will assist you to maximize these benefits.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary/ supplemental insurance benefits, including any referral documents from other medical providers. Current identification and insurance benefit cards are to be presented during your **first** appointment. As a courtesy to our patients, we submit all primary and secondary/supplemental claims.

FOR ALL MEDICARE PATIENTS: A doctor's referral is REQUIRED. Please present this at your first appointment to avoid any denial of claims or delay in payment.

FOR *ALL* PATIENTS: We require one upfront $25 supply fee to be paid during your FIRST APPOINTMENT.

I understand that my signature authorizes the payment of medical benefits from my insurance company to *Bodywise Physical Therapy.* My signature also authorizes the release of any medical information necessary to process my insurance claim(s).

Patient Signature: ______________________________

Cancellation Policy

***Bodywise Physical Therapy* has a strict 24-hour cancellation policy.** This ensures that all of our patients have the same opportunity to receive the highest quality of care, service, and personal attention.

Here is our breakdown of fees for any late cancelled/no-showed appointments:

- 1st Late Cancel/No Show: **FEE WAIVED**
- 2nd Late Cancel/No Show: **$75**
- 3rd Late Cancel/No Show: **$90**
- 4th or more Late Cancel : **$100**

Print Name: ______________________________

Patient Signature: ______________________________ **Date:** ____________

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Informed Consent for Physical Therapy Services

Physical therapy is a patient care service used to manage a wide variety of conditions. Services are provided to individuals of all ages, regardless of gender, color, religion, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury, and disability, by examination, diagnosis, prognosis, and intervention by use of rehabilitative procedures. Such procedures include but are limited to: mobilization, massage, therapeutic exercise, and dry needling. Any modalities used are focused on achieving rehabilitative and functional goals, within the realm of physical therapy.

Response to physical therapy intervention varies from person to person, therefore it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. *Bodywise Physical Therapy* does not guarantee that the treatment will help resolve the condition for which you are seeking treatment. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to refuse any part of treatment, at any time, regardless of circumstance. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, diagnosis, symptoms and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy. I agree to cooperate, participate, and comply with any physical therapy procedures within the established plan of care. **I also authorize the release of my medical information to any relevant third parties.**

Print Name: ____

Patient Signature: ______________________________ **Date:** ________

Automatic Payment Consent Form

Bodywise Physical Therapy **highly recommends** retaining a credit, debit, or HSA card on file for active patients. This information is kept strictly confidential in a password-locked form, and will only be used for payment of fees to *Bodywise Physical Therapy.* All patients have the option to automatically pay copays, late cancel fees, supply fees, and deductibles using this stored payment information. By providing us this necessary information, you greatly increase the amount of time spent with the physical therapist to receive the BEST patient care experience. If you would like us to allow us to bill your card automatically, please sign below.

*****WESTMINSTER PATIENTS---PLEASE NOTE*****

STARTING TUESDAY, JULY 30, 2019--ALL WESTMINSTER PATIENTS ARE REQUIRED TO HAVE AN AUTOMATIC CONSENT FORM ON FILE WITH US. PLEASE SEE BELOW FOR EXPLANATION OF OUR CHANGE IN POLICY, AND THANK YOU IN ADVANCE FOR YOUR ASSISTANCE!

- *Due to the lack of administrative support in our Westminster location, we do require those patients to have an "Automatic Payment Consent Form" on file. This greatly assists in allowing our physical therapists to provide optimal patient care by devoting the full appointment time to the therapy itself. Any charges will be made during the same services are rendered. WE GREATLY APPRECIATE YOUR COOPERATION WITH THIS CHANGE IN POLICY!*

Credit Card Information Authorization:
I authorize *Bodywise Physical Therapy* to charge my credit, debit, or HSA card for the balance of fees. I understand that if the amount charged is greater than $100, I will be notified of the amount my card is being charged for. All receipts and itemized statements will be provided to me upon request.

Cardholder Name:

____

Cardholder Signature:

____

Card Number:

____

Billing Zip Code:

____

CVC Security Code:

____

Expiration Date:

____

Card Type (please circle one): VISA MASTERCARD AMEX DISCOVER HSA

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Functional Dry Needling® Consent and Request for Procedure

Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension and will promote healing. This is not traditional Chinese Acupuncture but instead a medical treatment that relies on a medical diagnosis to be effective. The Physical Therapist will not stimulate any distal or auricular points during dry needling. Your physical therapist has met requirements for **Level 2 *(54 hours of training)*** competency in Functional Dry Needling® and is a certified Functional Dry Needling® Practitioner. All training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If this occurs, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands, it should not be a major concern. Other risks include: injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Procedure: I, ______________________________, authorize practitioners of ***Bodywise Physical Therapy*** to perform Functional Dry Needling®

Please answer the following questions:

Are you pregnant? Yes No **Are you immunocompromised?** Yes No **Are you taking blood thinners?** Yes No

*****DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM*****

You have the right to withdraw consent for this procedure at any time before it is performed

______________________________ ____________ ____________
Patient or Authorized Representative Signature Date Time

______________________________ ______________________________
Relationship to patient (if other than patient) (Patient name printed)

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

______________________________ ____________ ____________
Physical Therapist Signature Date Time

☐ Patient was offered copy of consent and refused ☐ Patient was given copy of consent

EVERY Patient being treated in Westminster must have a SIGNED WAIVER

CBRE

WESTMOOR CENTER

<u>FITNESS CENTER AGREEMENT AND RELEASE AND WAIVER</u>

I understand that the Fitness Center (defined below) is provided as a convenience by Keppel-KBS Westmoor Center, Inc., a Delaware Corporation ("Owner"), and that Owner makes no representation, warranty or guarantee as to the safety or efficacy of the Fitness Center. Owner has retained CBRE, Inc. ("Manager" or "Management") as its property manager at Westmoor Center, 10055-10385 Westmoor Drive, Westminster, Colorado (the "Project"), and has, for the use and enjoyment of the tenants and the employees of the Project, established an indoor exercise area located at 10155 Westmoor Drive (Building 3), Unit 185 (the "Fitness Center"). In consideration of the license to the use of the Fitness Center, I ________________ hereby agree to the following:
(write name)

1. The Fitness Center is intended for the exclusive use of Members only. A "Member" shall mean the Project's tenants' employees and employees of the Project over the age of 18 who have executed this Fitness Center Agreement And Release And Waiver ("Agreement") and whose rights to use the Fitness Center have not been terminated.

2. Member is hereby granted the non-exclusive right to use the Fitness Center during the times specified for use by Manager. Said times are subject to change or modification. Our Fitness Center current hours are:

Monday through Friday	5:00 a.m. to 8:00 p.m.
Saturday	8:00 a.m. to 1:00 p.m.
Sunday	Closed

3. Owner and Manager are not responsible for any loss, damage, or theft of any of Member's personal or corporate property from the Fitness Center.

4. The Fitness Center is an unsupervised and unattended facility, and the use of any equipment or participation in any fitness or exercise class is strictly at the Member's own risk.

5. Member shall abide by the Rules and Regulations of the Fitness Center (the "Rules"), which are attached hereto as Exhibit A and incorporated herein by reference. The Rules may be modified by Manager from time to time. Effective notice and delivery of such change shall be accomplished by posting in a conspicuous location in the Fitness Center or by distributing the amended rules to the office of all tenants of the Project. By executing this Agreement, Member acknowledges he/she has received a copy of the Rules that he/she has read and understands them and agrees to abide by them without exception.

6. There shall not be any fitness and exercise classes at the Fitness Center without prior written consent of Manager or Owner.

7. By signing this Agreement, Member confirms that they are in good health and know of no reason why they should not exercise at a nominal level for their age, weight, and height. No matter what Member's age, attempted weight training or physical exercise without a thorough physical examination and with physician's approval of the planned exercise regimen could be dangerous and should be avoided.

8. Member's right to use the Fitness Center is subject to termination, with or without cause, at any time, by Manager or Owner. Member's right shall terminate immediately upon Member's termination of employment with a tenant in the Project. Member's failure to abide by this Agreement and all the Rules contained herein shall result in the immediate termination of their right to use the Fitness Center.

9. I further agree and acknowledge the following:

RELEASE AND WAIVER – READ CAREFULLY

I know that exercising and use of the Fitness Center can be dangerous to my health and life due to equipment defects or malfunctions, negligence on the part of other users or in the maintenance of the equipment, and the strenuous activity inherent in the use of exercise equipment. I understand that I should consult with a physician before undertaking any physical regimen. In consideration for permission to use the Fitness Center (exercise room, exercise equipment, locker room and shower facilities including restrooms) in Westmoor Center, my heirs, executors, administrators and assigns, forever and irrevocably waive, release and discharge and covenant NOT TO SUE Keppel-KBS Westmoor Center, Inc., a Delaware corporation, the designated property manager for the Westmoor Center, and CBRE, Inc., or their respective members, affiliates, mortgagees, representatives, successors or assigns (the "Owner Parties"), from any and all demands, claims or liability for death or injuries to me (including my guests), and for any damages to my property, arising directly or indirectly out of or in connection with the use of the Fitness Center. This Release and Waiver extends to all claims of any kind or nature, whether foreseen or unforeseen, known or unknown, resulting directly or indirectly from my use of the Fitness Center. I further understand none of the Owner Parties assumes any responsibility for and is not obligated in any way to provide financial assistance or other assistance, including but not limited to medical, health, or disability insurance, in the event of injury, illness, death or damage arising from or related to use of the Fitness Center.

I understand that I may store my exercise equipment and personal items in the lockers while I am actually exercising in the facility but must remove them when I am finished exercising. Furthermore, if I leave any items in the lockers all day or overnight, the lock may be removed, and the items inside may be discarded and in no event shall the Owner Parties have any duty to safeguard or store such items. I acknowledge that none of the Owner Parties are responsible for my lost or stolen property from the locker or the Fitness Center.

I agree to abide by the rules and regulations attached hereto as Exhibit A. I acknowledge Landlord reserves the right, in its sole discretion, to impose future charges for using the Fitness Center, institute new rules and regulations, relocate the Fitness Center, or even discontinue providing the Fitness Center.

I have read and understand the above and sign this Fitness Center Agreement and Release and Waiver voluntarily and with full knowledge of its significance.

SIGNATURE: ______________________________

PRINT NAME: ______________________________

COMPANY: ______________________________

DATE: ______________________________

SUITE: ______________________________

CARD ACCESS #: ______________________________

Contact Phone #: ______________________________

EMERGENCY CONTACT______________________________

EXHIBIT A

WESTMOOR CENTER FITNESS CENTER RULES AND REGULATIONS

Westmoor Center - Fitness Center is managed by CBRE INC. whose office is located at

10155 Westmoor Drive, Suite 105, Westminster, Colorado 80021 | Telephone 303-466-5588

ALL PERSONS USING THIS FACILITY AGREE TO ABIDE BY THE FOLLOWING RULES AND REGULATIONS:

1. No food or beverages other than what is contained in water bottles are allowed at any time.
2. Please wipe down equipment before and after each use.
3. The Fitness Center is not a supervised facility. Members are responsible for their safety. Use at your own risk.
4. Your personal physician should be consulted prior to using any of the equipment or taking part in any fitness exercise or fitness classes.
5. Pregnant women, or those with any physical, mental or cognitive problems, should exercise only under the supervision and advice of a physician or other healthcare professional.
6. Appropriate clothing, including shirts and gym shoes, must be worn when using the Fitness Center.
7. Any maintenance items, security concerns, or any problems of a management nature should be reported immediately to the management office.
8. LOCKERS ARE FOR DAY USE ONLY. ALL ITEMS MUST BE REMOVED FROM LOCKERS EACH DAY. All items left overnight may be removed by management at owner's risk.
9. Management is not responsible for lost, damaged or stolen items.
10. No bicycles are allowed in the Fitness Center at any time for any reason.
11. Have fun!