BodyIntel Patient Information Sheet

Patient Information:			
Patient Name:			
Address:	**City:**	**State:**	**Zip Code:**
Home Phone:	**Work Phone:**	**Cell Phone:**	
Date of Birth:	**Social Security No:**		
Employer/School:	**Occupation:**		
E-mail Address:	**How did you hear about us?**		
Physician's Name:	**Physician's Phone Number:**		
Area(s) to be treated:	**Date of Injury/Onset of Symptoms:**		
Surgery: ☐Yes ☐No Date of Surgery________________	**Other Comments:**		
Spouse, Parent/Guardian, Other:			
Name:	**Relationship to the patient:**		
Address:	**Phone Number:**		
Employer:	**Work Phone:**		
In Case of Emergency, whom shall we contact? ( ) -			
Insurance Information:			
Primary Ins. Company:	Phone #:		
Address:	City:	State:	Zip Code:
ID/Claim Number:	Group Number:		
Insured Name:	DOB:	Relationship to the Patient:	
Secondary Ins. Company:	Phone #:		
Address:	City:	State:	Zip Code:
ID/Claim Number:	Group Number:		
Insured Name:	DOB:	Relationship to the Patient:	

For Office Use Only:					
Date Verified:	Effective Date:		Insurance Rep Name:		
In-Network % Covered:			Out of Network % Covered:		
In-Network Deductible:			Out of Network Deductible:		
Amount Met:			Amount Met:		
Co-Pay:	Visits:	Auth$:	Co-Pay:	Visits:	Auth$:
Auth# (Pre-cert#):			Auth# (Pre-cert#):		
Auth to:	Auth From:		Auth to:	Auth From:	
Comments: Family/Deductible/Met?					
BodyIntel Inc. Rep:			Pt. notified of benefits: ☐Yes ☐No Date:		

The information I provided in the medical history, patient information and insurance sections are accurate to the best of my knowledge.

Patient Signature:____ Date:________________

BodyIntel Medical History

Patient Name:	**Date:**
Reason for visit:Error! Not a valid bookmark self-reference.	
Check which apply to the nature of your visit: ☐Athletic/Recreational Injury ☐Work related injury	☐Motor Vehicle Accident ☐Other:
Name of physician:	
Date of next physician visit:	
Have you had diagnostic tests: ☐X-ray ☐MRI ☐Other_________________________________ **Please bring written report of tests if available.**	
Have you had a related surgery? ☐ yes (Procedure and Date)________________________ ☐ no	

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest Pain	☐	☐	Allergies to Heat/Cold	☐	☐
High Blood Pressure	☐	☐	Other Allergies:	☐	☐
Heart Disease	☐	☐	Blood Disorders	☐	☐
Stroke	☐	☐	HIV/AIDS	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
High blood cholesterol	☐	☐	Thyroid dysfunction	☐	☐
Headaches	☐	☐	Dizziness/Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Cancer	☐	☐	Surgeries:	☐	☐
Are you pregnant?	☐	☐	Skin Abnormalities	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Sexual Dysfunction	☐	☐
Urine leakage	☐	☐	Nausea/Vomiting	☐	☐
Asthma/Breathing Difficulties	☐	☐	Ringing in your ear	☐	☐
Liver/Gallbladder Problems	☐	☐	Rheumatoid Arthritis	☐	☐
Smoking	☐	☐	Special Diet guidelines	☐	☐
Other:	☐	☐	Hypoglycemia	☐	☐

if YES to any of the above, please briefly explain and provide approximate date (s):

____

____

Is there any other information regarding your past medical history that we should know about?

____

____

Are you presently taking medication: YES NO If YES, please list medications and for what condition:

____

____

BODYINTEL LLC AGREEMENT OF RELEASE AND WAIVER OF LIABILITY

I will receive information and instruction while participating in class, health program or workshop offered by BodyIntel, LLC. I recognize that the Physical Therapist or Pilates Instructor will require physical exertion, which may be strenuous and may cause physical injury. I am 100% aware of the risks and hazards.

1. I understand that is my responsibility to consult with a physician prior to and in regards to my participation in the session or any other activity associated with BodyIntel, LLC. I represent and warrant that I am physically fit and have no medical conditions that would prevent my full participation in my session, health program or workshop at BodyIntel, LLC.
2. I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I may incur as a result of participating in the program at BodyIntel, LLC.
3. I knowingly voluntarily and expressly waive any claim that I may have against the BodyIntel, LLC Physical Therapist, Pilates Instructor or MAT specialist.
4. Heirs, my legal representative and I forever release and waive any liabilities against BodyIntel, LLC and its staff for any injury or death incurred by voluntary participation in this class, workshop or activity.

I have read the above release and waiver of liability and fully understand their contents. I voluntarily agree to the terms and conditions stated above.

Date:____

Signature of Participant:____

If participant is under the age of 18, as legal guardian of:

Name

Minor:____ I consent to above conditions:

Signature of Parent/Guardian

Participant:____

DRY NEEDLING CONSENT FORM

Dry Needling Therapy is a valuable treatment technique in managing chronic pain, acute pain, muscle stiffness and spasm, edema/swelling, and painful muscle trigger points. Like any treatment procedure, there is risk for complications, and while these are uncommon they can occur and must be appropriately outlined prior to consenting to its use.

Dry Needling uses a thin, flexible, sterile needle to promote muscle relaxation, while increasing the ability of tissue to heal, and often results in pain relief. Dry Needling technique uses the same type of needles used in Acupuncture. However, Dry Needling treatment perspective is based solely on modern physiology, neurology and biomechanics, rather than the ancient Traditional Chinese/Asian Theory of the energy, "Chi". Dry Needling is termed "dry" because at no time will a fluid or medication, be injected into your body. It therefore can be considered a natural therapy to help manage pain and injury.

Risks: The most serious risk with Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, 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.

If you currently have an; infection, cancer, hepatitis, HIV/AIDS, a pacemaker, are taking blood thinners and/or immunosuppressant medications (decreasing the strength of the immune system), then please inform your health care provider prior to beginning treatment.

I have read or have had this form read to me; and I understand the risks involved with Dry Needling Therapy. I have had the opportunity to ask questions and express any concerns, of which have been answered to my satisfaction. A copy of this form will be provided to you today.

I consent to Dry Needling Therapy treatment by my health care provider.

Print Name: ____ Date: ______________

Signature: ____

BodyIntel Financial Sheet

POLICIES: Financial, Appointment Cancellations/Fees, and Consent to Treat

Patient Name: _________________________________Clinic Name: BodyIntel, LLC

Thank you for choosing BodyIntel for your health needs. We are truly committed to your treatment leading to a successful recovery. Please understand that payment of your bill is considered part of your treatment. This is a

financial responsibility on your part that obligates you to ensure full payment of your bill. All patients must complete our information and insurance form before they see a therapist.

<u>Regarding Your Insurance---IMPORTANT!</u>

You are responsible for payment of any deductible, co-payments and co-insurances as determined by your contract with your insurance company. All co-pays and co-insurances are due at the time of treatment. In the event that your insurance changes to a plan where we are not participating providers, refer to the above paragraph. It is your responsibility to ensure that we are notified of any changes in your insurance coverage. It is your responsibility to know your benefits. Health insurance is not accepted for motor vehicle claims, workers compensation claims or personal injury claims with a 3rd party liability. **All patients covered under a motor vehicle claim must pay for their treatments if BodyIntel is not reimbursed within 3 months.** Referrals and treatment authorizations are ultimately the responsibility of the patient. Any visits that are performed and not covered by your insurance company because you have not obtained authorization, have not presented a valid referral, or have attended therapy beyond your benefit period, become solely your financial responsibility. If you receive a payment from the insurance company for services rendered by BodyIntel you must reimburse BodyIntel at the time of receipt of such payment. **If you have a secondary insurance you must present it at your initial visit.** We will not retroactively bill a secondary insurance if you fail to provide all the necessary insurance information. That balance will then become yours and you will have the responsibility of submitting the claim to your secondary insurance company. The patient agrees that if he/she defaults on any balance owed to BodyIntel and it becomes necessary for BodyIntel to engage the services of an attorney, collection agency or other lawful method of collection, the patient will pay the original balance owed, in addition to reimbursing BodyIntel 33 1/3% of the entire balance for legal fees, interest of 12% on the entire balance, plus court costs incurred in the collection of said debt. **In-Network Participating Provider/ Out-of-Network Provider/ Non-Capitated Provider**

<u>Regarding Insurance Billing:</u>

As stated earlier, we bill your insurance carrier on your behalf as a courtesy to you. We will bill your insurance carrier up to two times to ensure payment of your benefit for services rendered by BodyIntel. However, in the event that billing of your insurance carrier does not satisfy your balance for services rendered, we will have no choice but to look to you for full settlement of your account. Please ensure that you have submitted the appropriate insurance.

<u>Estimated Financial Responsibility:</u>

Insurance plans, fee schedules and reimbursement rates frequently change. Every effort is made to stay current with these changes. Based on our current knowledge of your insurance plan, we have estimated your personal per-visit contribution for services rendered by BodyIntel. BodyIntel charges are usual, customary, and reasonable for this geographic region. These charges are established based on current-year data supplied by Medicode Corporation and Medical Data Research, Inc., (MDR), two independent firms who conduct geographical fee surveys. Our charges are in-line with the industry averages for physical therapy services in this geographical area.

Your estimated financial contribution <u>per visit</u>, after your health insurance carrier has made payment is: $ ______.
(X________(BodyIntel, Staff Initials)

BodyIntel Financial Sheet

POLICIES: Financial, Appointment Cancellations/Fees, and Consent to Treat

This is only an estimate based on historical co-payments/co-insurances with your health insurance carrier. In the event that your insurance carrier does not pay your claim and we have exhausted all means with your insurance carrier, we will set up a patient payment arrangement with you. You may wish to contact our office for a more detailed explanation and for payment options that are available. The estimated financial responsibility quote above does not include any additional amounts that may be owed to satisfy your deductible, if any. Refunds for any amount less than $5.00 will not be given unless requested in writing by the patient.

I have read the Financial Policy. I understand and agree to this Financial Policy& I acknowledge receipt of this document.

X___________________________________ **Date______________**

Signature of Patient/Responsible Party

<u>Missed Appointments and Late Charges:</u>

Please, if you cannot attend your scheduled appointment, call to cancel it within 24 hours and reschedule it as soon as possible. We do make exceptions for true emergencies, but please call in as early as possible. All appointments that are missed without being cancelled within 24 hours are billed to you, not your insurance carrier. Our standard charge for missed appointments, without being cancelled by you, is $35.00 for the first offense and the full price of your session subsequently. On your invoice you will see this as a “NO SHOW” charge. A $15.00 late fee will be assessed on all unpaid balances.

I have read the Cancellation Policy and I understand that a cancellation must be made 24 hours in advance of my scheduled appointment to avoid being charged a cancellation fee. I also understand that a $15.00 late fee will be assessed on all unpaid balances.

X___________________________________ **Date______________**

Signature of Patient/Responsible Party

<u>Expiration of Physical Therapy, Pilates and Massage Packages:</u>

All service packages will expire three months after the date of purchase. Gift certificateswill expire within 6 months from the date of purchase.

X___________________________________ **Date______________**

Signature of Patient/Responsible Party

<u>Consent to Treat and Authorization to Release Information, and Assignment of Benefits:</u>

I hereby authorize BodyIntel through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize BodyIntel to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment. I am assigning my physical therapy benefits to BodyIntel for the services in which I receive and authorize my insurance carrier to make payments to BodyIntel on my behalf. All records released require an administrative and copying fee paid to BodyIntel before they are released, regardless of the requestor. The adult accompanying a minor and the parents (guardians) are responsible for full payment. BodyIntel is HIPPA compliant with regard to information sharing policies.

X___________________________________ **Date______________**

Signature of Patient/Responsible Party

BODYINTEL CANCELLATION POLICY

At BodyIntel, we are excited when we see your name on the schedule and are already planning on how we can make your time spent at BodyIntel most valuable. Once we have mentally and physically prepared for your session, it is a bummer when we get a "no show."

We acknowledge that life happens and that emergencies will come up. In order to avoid a late cancellation or no show charge, all cancellations must be made 24 hours prior to the session. For Monday appointments, we require you to cancel by the previous Friday at noon to avoid a late charge. This policy was made to protect the staff members, as their paycheck is directly related to the number of clients they see. This ensures our staff has a stable compensation, which means BodyIntel can hire and keep the BEST of the BEST!

Late charges for classes are $25/class, $50 for a first time private PT or Pilates session, and the full price of private PT or Pilates for subsequent missed sessions.

Weather Policy… Colorado's weather is amazing and unpredictable. With severe weather, please be aware we may have last minute schedule changes. BodyIntel will call you to cancel and reschedule any sessions affected by severe weather. If BodyIntel remains open and classes are remaining on the normal schedule, the late cancellation policy still applies. Your safety and well-being are most important to us. If you feel unsafe driving due to weather conditions, please let us know in advance so we may modify our schedules.

1574 South Pearl Street Denver, CO 80209
Phone: (303) 777-5263
Fax: (303) 777-5268