Welcome to The Body Haus Pilates & Physical Therapy and thank you for choosing us as your partner in health and fitness. We are committed to providing our patients with the highest quality care.

POLICY INFORMATION

The enclosed materials are Patient-Physical Therapy Disclosure Documents for The Body Haus LLC., d/b/a The Body Haus. Before proceeding with any physical therapy treatment, you are encouraged to read the enclosed documents and provide relevant information, as well as signatures acknowledging receipt, understanding, and any permissions or consents being requested.

If you should ever have any information regarding these Patient-Physical Therapy Disclosure Documents, please contact us at the numbers listed below at the close of each page.

Name: _____Age: _____

Birthday Month: _____ Day: _____

Address: _____

Mobile #: _____ Home #: _____

Email: _____

Occupation: _____

Where did you hear about us: _____

How do you prefer to be contacted? _____

Do we have permission to leave messages with information regarding appointments or treatments? _____

EMERGENCY CONTACT INFORMATION:

Name of Contact: _____ Relationship to you: _____

Phone #: _____ Email: _____

PHYSICAL THERAPY INFORMATION:

What are your goals for physical therapy?_____

Were you referred by a physician? If so, who?_____

When do you see your physician again? _____

Please explain your injury/condition including onset date _____

_____

_____

_____

What activities aggravate your symptoms? _____

_____

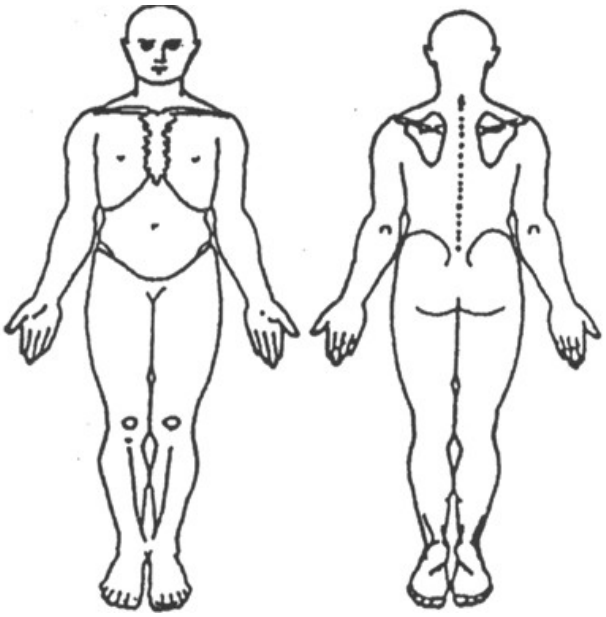
_____

Describe any previous treatments for this condition: _____

_____

_____

Have you had any diagnostic tests for this condition? X-ray MRI CT Scan Doppler Ultrasound



Please mark the location of your pain on the diagram to the left.

Please describe your pain:

Sharp / Burning / Aching / Tingling / Numbness /

Other:
_____

Please rate your pain (0 = none, 1 = minimal, 10 =
severe):

At present: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10

Please list any other pertinent information that you would like your physical therapist to know below: _____

_____

_____

_____

CONSENT FOR PHYSICAL THERAPY

Please print all pages, fill out, sign and bring with you to your first appointment.

A. Physical therapy. In the state of Ohio, physical therapists can see you without a medical referral for wellness, fitness, prevention purposes, and for physical therapy.

1. With consent of the patient, the physical therapist shall notify the patient's physician within 5 business days of a physical therapy evaluation.
2. If the physical therapist determines, based on reasonable evidence, that no substantial progress is made with respect to the patient in 30 days following the initial evaluation the patient will be referred to an apporiate referral based on the State of Ohio practice laws.
    a. Exclusions include fitness, wellness, and prevention services and/or if the patient has been previously diagnosed with a chronic, neuromuscular, or developmental condition.
3. If, at any time, the physical therapist has reason to believe that the patient's symptoms or condition requires treatment or services beyond the scope of practice of a physical therapist that individual shall refer the patient to an appropriate licensed health care practitioner.

B. Insurance. The Body Haus does not accept insurance, but may be considered an out-of-network provider with some companies. Please check with your provider prior to services for information necessary to bill your carrier after services have been provided. **I understand that The Body Haus physical therapy services are billed to the patient and that full payment is due at the time of service**.

C. Medicare. In order for a patient who has Medicare to be treated by The Body Haus the patient must first verify:

a. Services are non-covered because they are not defined as a Medicare benefit under the statute; ie. Wellness, prevention, and fitness programs
b. Services are non-covered because they are not considered "reasonable and necessary"

I have verified that physical therapy services are not covered under the Medicare program and understand an Advanced Beneficiary Notice may need to be issued prior to treatment. **I understand that The Body Haus physical therapy services are billed to the patient and that full payment is due at the time of service.**

4. **Informed consent for treatment.** The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The Body Haus provides a wide range of services. **I understand that I will receive information from The Body Haus at the initial visit concerning the treatment and options available for my condition.**

5. **Potential benefits.** Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me. Nevertheless, benefits are not guaranteed nor guaranteed to be permanent. **I understand that The Body Haus does not provide a guarantee and that potential benefits may be temporary.**

6. Potential risks. I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. **I understand that it is my obligation to keep The Body Haus informed of my present condition and any unanticipated pain or discomfort as a result of physical therapy**

7. **No warranty**. My physical therapist at The Body Haus will share with me his or her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. **I understand that my physical therapist at The Body Haus cannot and will not make any promises or guarantees regarding a cure for or improvement in my condition.**

8. **Alternatives.** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider. **I understand that The Body Haus will not endorse, recommend, or suggest any alternative, and any discussion or acquiescence thereof is not to be interpreted as an endorsement, recommendation, or suggestion.**

9. **Cancellation Policy.** PUKKA requires that appointment cancellations be made within 24 hours. There is a full $80 service fee for no---shows or cancellation without proper notice. If I cancel my physical therapy appointment without proper notice or no-show, I agree to pay the $80 service fee.

THE UNDERSIGNED ACKNOWLEDGES HAVING READ AND UNDERSTOOD THE ABOVE INFORMATION. THE UNDERSIGNED HEREBY CONSENTS TO PHYSICAL THERAPY EVALUATION AND TREATMENT BY THE BODY HAUS. I THE UNDERSIGNED ALSO ACKNOWLEDGES HE OR SHE WILL ABIDE BY THE CONDITIONS AND POLICIES NOTED ON THIS CONSENT FORM.

Name (Please Print) Signature Date

If signing on behalf of a patient as a Guardian, Agent, or other Legal Representative:

Name (Please Print) Signature Date

Relationship (if Applicable)