Medical History Information

Name:____ DOB:__________________
Age: ________

Address:_____________________________________
City:___________________________________

State:_______ Zip:_________ Phone #:______________________ Text Reminders OK? Y N

Is your above address also your billing address for credit card on file? Yes No

Do you have **Medicare** coverage for your health insurance? Yes No

Email:____

Emergency Contact Name:______________________________ Phone #:_____________________

Relationship to you:____________________________________

Occupation (past or present):____

How were you referred/recommended to us:____

Primary Physician: ____________________________________ Phone #:_____________________

Specialist Physician:____________________________________ Phone #:_____________________

Did you inform your physician that you are starting Physical Therapy and/or Pilates? Yes No

Have you had any change in health status over the last 12 months? Please include any **injuries, surgeries, new diagnoses or new medication.**

____

____

Please list all supplements, over the counter and prescription medications that you are taking:

1.______________________ 2.____________________ 3.______________________

4.______________________ 5.____________________ 6.______________________

7.______________________ 8.____________________ 9.______________________

Women: Are you (or could you be) pregnant? Yes No

Number of pregnancies:______ Vaginal or Cesarean delivery (circle)

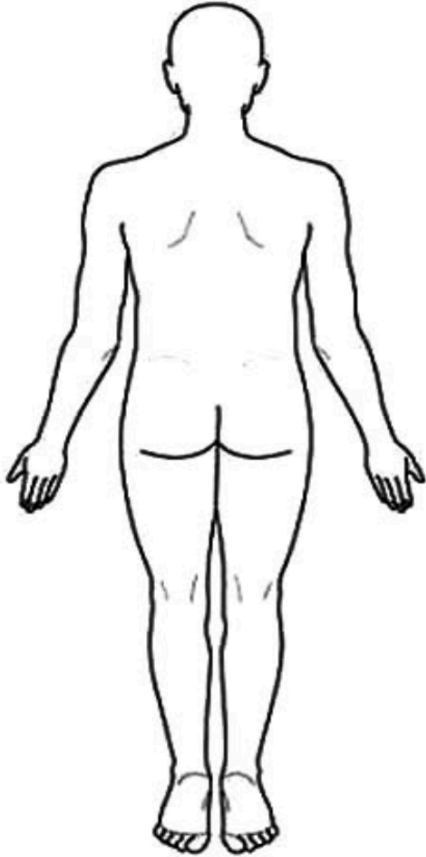
Have you or any immediate family member (parent, sibling, child) been told you have (circle):

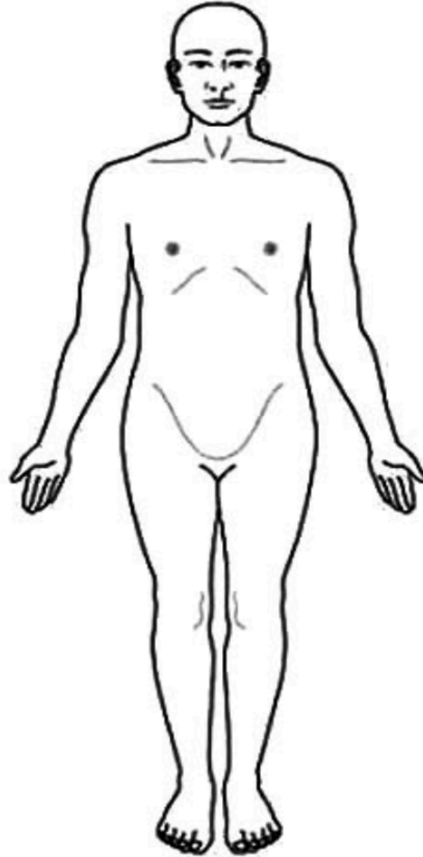
Allergies	Depression	Liver Disease
Arthritis	Diabetes	Osteoporosis/Osteopenia
Asthma	Eating Disorder	Shortness of Breath
Cancer	Heart Problems	Skin Problems
Chemical Dependency (alcohol/drugs)	High Blood Pressure	Stroke
	Joint Replacement	Thyroid Problems
Circulation Issues	Kidney Disease	Varicose Veins

If any are circled, please explain:____

Please mark any areas of symptoms in your body

RENEW
PHYSICAL THERAPY & PILATES





On a scale of 1-10, what is your current pain level?_______ Best:________ Worst:________

My signature gives my consent to be treated. I understand that I always have a right to refuse treatment and/or ask questions for any reason if I am uncomfortable with the options recommended.

______________________	____________________________	__________
Patient/Client name (print) (or parent if minor)	Signature	Date

Studio Policies

All sessions are approximately 55 minutes in length

All group class sessions are subject to a 24hr cancellation policy (via text and email) if only one participant is signed up.

Grip socks are required for your safety and hygiene, please launder after each use

Please arrive no more than **5 min before** your scheduled class or appointment start time.

Our studio will only be using the new Balance Body Vinyl-covered straps for Reformers, Pilates Chairs, CoreAlign, and Trapeze Table. The non-porous vinyl covering allows for complete cleaning.

We have studio towels for your one-time use while at the studio all washed in HOT on Sanitize Cycle.

No cell phone usage during all Pilates sessions, please silence your phones before entering the studio

Pilates Starter sessions required (if new to Pilates) prior to joining group classes. It includes 3 private sessions for orientation to the apparatus and safety + 2 group classes

All sessions are non-refundable and non-transferable with a 3 day “oops” refund policy

Private Pilates/Physical Therapy missed appointment or late cancel fee (within 24 hour window) will result in a $50 fee and classes will be charged at the regular class price

Pre-payment credit card preferred method to minimize contact points.

5 and 10 packs have a 6-month expiration and 20 pack has a 12-month expiration

If at checkout, you do not have class credits on your account, we will charge a DROP IN class charge and reach out to you to assist in purchasing a class package moving forward.

Messages left on the business line will be returned within 24 business hours.

To avoid congestion at the front desk, please email us at support@renewPTpilates.com with your questions or concerns and we will contact you as quickly as we can in response

Receipt of Studio Policies Information

CLIENT NAME
(print):____
_

SIGNATURE: ____
DATE:___________________

General Release of Liability

I ______________________________ hereby agree to the following:

I am participating in physical activity at Renew Physical Therapy & Pilates, LLC which may include, but is not limited to Pilates-based exercise programming (Pilates Reformer, Trapeze Table, Combo Chair, Fuse Ladder, CoreAlign, Bodhi, etc) and/or physical therapy services rendered by a licensed physical therapist in the state of Colorado. I recognize that any physical activity may be strenuous and may cause injury, and I am fully aware of the risks and hazards involved in such activity including serious personal injuries, paralysis, and death.

I represent and warrant that I am physically fit and I have no medical conditions that would prevent my full participation in these classes/private sessions. I understand that it is my responsibility to consult my physician prior to initiating Pilates-based exercise programming regarding my participation in these classes/private sessions. If I have any existing medical conditions, I have been cleared by my doctor to participate in activities at Renew Physical Therapy & Pilates, LLC and have explained in detail on the intake forms and in person.

In consideration of being permitted to participate in these classes and/or private sessions, I agree to assume full responsibility for any risks, injuries or damage, known or unknown, which I might incur as a result of participation in these activities or as a result of negligence. In further consideration of being permitted to participate in these classes, I knowingly, voluntarily and expressly waive any claim I may have against Renew Physical Therapy & Pilates, LLC for injury or damages that I may sustain as a result of participating in these activities.

I, on behalf of myself, my family, heirs, successors, assignees, and anyone claiming any interest through me, hereby KNOWINGLY, INTENTIONALLY, AND VOLUNTARILY WAIVE, RELEASE, INDEMNIFY AND AGREE TO HOLD HARMLESS RENEW PHYSICAL THERAPY & PILATES, LLC, all agents of Renew Physical Therapy & Pilates, LLC and all landowners (owned, leased or otherwise) FROM ANY AND ALL ACTIONS, SUITS, CLAIMS, DAMAGES, AND LIABILITY.

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

Signature of Participant:_____________________________________
Date:________________

____

Parent/Guardian Signature for Participants of Minority Age (under 18 yo)

Appointment Cancellation and No-Show Policy

Our goal is to provide quality individualized physical therapy and/or Pilates services in a timely manner. No-Shows and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to clearly state our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of physical therapy and/or Pilates services.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please be courteous and email or call Renew Physical Therapy & Pilates, LLC promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and we often have a wait list for patients that were unable to schedule with their therapist and your early cancellation will give another patient the possibility to have access to timely care.

How to Cancel Your Appointment

To cancel an appointment send an email to support@renewPTpilates.com. You can also call 303-284-8752. If you do not reach someone in person, please leave a detailed message on our confidential voicemail.

Late Cancellations

A cancellation is considered late when a patient fails to cancel their scheduled appointment with a 24 hour advanced notice. Consideration will be given in the event of adverse weather conditions, school closures, illness and extenuating circumstances.

No-Show Policy

A no-show is when someone misses an appointment without cancelling and/or fails to acknowledge their absence from a scheduled visit.

1st Late Cancel / No-Show there will be no charge

2nd+ Late Cancel / No-Show there will be a $50 fee

I acknowledge receipt and understanding of the cancellation and no-show policies at Renew Physical Therapy & Pilates, LLC.

Signature:____ Date:_____________________

Consent to Treatment: Authorization to Release Information , Statement of Financial Responsibility

Patient Name:____________________________________ Date:___________________

Renew Physical Therapy & Pilates, LLC acknowledges and appreciates the confidence you have shown in choosing us to provide your physical therapy needs. Our office is committed to providing you a quality one-on-one 55 minutes appointment with a skilled, Colorado licensed physical therapist. We are an out-of-network physical therapy provider, meaning we do not contract with any insurance companies including Medicare, Medicaid and private insurance companies. The services you have entered into with Renew Physical Therapy & Pilates, LLC implies a financial responsibility. You are ultimately responsible for payment of your bill. If your account is not paid in full and is sent to a collection agency, any fees incurred in collecting your unpaid balance will be your responsibility.

I have read the financial policy of Renew Physical Therapy & Pilates, LLC for providing rehabilitation services to the above named patient. I attest to the information provided being accurate and true. I agree to pay Renew Physical Therapy & Pilates, LLC the full and entire amount of all bills incurred by me or the minor I am responsible for.
Signature:____
Date:______________________

I acknowledge that the *Notice of Privacy Practices* and a link to the *Notice of Federal Civil Rights and Health Insurance Portability and Accountability Act of 1996* are posted onsite at Renew Physical Therapy & Pilates, LLC located at 8182 S. Holly St, Centennial, CO 80122 where I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.
Signature:____
Date:______________________

Consent of Treatment and Authorization to Release Information. I am aware of my diagnosis and voluntarily consent to have Renew Physical Therapy & Pilates, LLC through its licensed and certified personnel, provide evaluation and treatment as prescribed by my physician and/or recommended by my licensed physical therapist. I understand that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand I have the right to ask questions at any time during my rehabilitation care.
Signature:____
Date:______________________

I acknowledge that this is a cash-based physical therapy practice. If I choose to self-submit paperwork to my private insurance company, automobile claim or worker's compensation claim, I will inform my therapist of this **prior** to needing documentation, CPT and ICD-10 coding, and an itemized billing statement. I agree to pay the full posted physical therapy service rate at Renew Physical Therapy & Pilates.
Signature:____
Date:______________________

Patient Information Consent Form (HIPPA)

Consent to Physical Therapy Evaluation and Treatment
I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist at Renew Physical Therapy & Pilates, LLC. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Patient Information Consent Form (HIPAA Health Information Portability & Accountability Act)
I have read and fully understand Renew Physical Therapy & Pilates, LLC's Notice of Privacy Practices. I understand that Renew Physical Therapy & Pilates, LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Renew Physical Therapy & Pilates, LLC will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Renew Physical Therapy & Pilates, LLC'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, at which point Renew Physical Therapy & Pilates, LLC has 30 days to respond to my request.
Link to HIPPA: Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Release of Information
I hereby authorize the release of information to individuals listed below. Designated Individuals Authorization I, __________________________, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below. Authorized Designees:

Name:____
Relationship:_______________________________________
Name:____
Relationship:_______________________________________
Name:____
Relationship:_______________________________________

I have read and understand the above consents, release of information, and designated individuals authorization above.

Patient Signature _______________________________________
Date____

Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or

- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.

- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.

- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.

- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a “CO-DOI” on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Surprise/Balance Billing Disclosure Form

STATEMENT OF CONSENT I confirm that I have read and understand the above information regarding surprise/balance billing. I acknowledge that I am receiving out-of-network services at Renew Physical Therapy & Pilates. I understand I am not responsible for surprise or balance billing.

Signature:____

Patient Name (Print):______________________________________
Date:________________

Physical Therapist Signature:____

Notice of Privacy Practices

RENEW PHYSICAL THERAPY & PILATES, LLC NOTICE OF PRIVACY PRACTICES

Effective June 1, 2020

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

Renew Physical Therapy & Pilates, LLC is required by law to provide you with this notice that explains our privacy practices in regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as other purposes permitted or required by law. You have certain rights regarding the privacy of your protected health information as described below.

Renew Physical Therapy & Pilates, LLC is committed to maintaining the privacy of your protected health information and is required to abide by the privacy policies and practices listed in this notice.

Ways in which we may use and disclose your protected health information:

Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating, diagnosing, and providing treatment.

Payments Your health information may be used to seek payment from other sources of coverage such as automobile insurer, employer for worker's compensation claims, or from credit card companies that you have used to pay for services at Renew Physical Therapy & Pilates, LLC. For example, requests may be made for dates of service, services provided, and medical conditions being treated.

Appointment Reminder Your health information will be used by our staff to contact you regarding appointment reminders. If you prefer appointment reminders not be left on your voicemail or sent through email, please notify us in writing and we will make that accommodation.

Others Involved in Your Care When necessary, we will use and disclose your protected health information to a family member, a relative, a close friend, or anyone else you specifically identify who is involved in your medical care or payment for care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure is in your best interest, we may share limited personal health information with involved individuals without your approval.

As Required by Law We will use and disclose your protected health information as required by federal, state or local law authorities.

Worker's Compensation We will use and disclose your protected health information for worker's compensation that provide benefits for work-related injuries in accordance with state law.

Clinical Outcomes Improvement We will use and disclose your protected health information for the purposes of improving clinical outcomes and patient care, peer reviews and business management purposes.

Your Health Information Rights:

Receipt of a Paper Copy of this Notice Upon request, we will provide you a paper copy of our Notice of Privacy Practices. It is also posted on our website at www.renewptpilates.com

Other Uses or Disclosure:

The above is not conclusive in its entirety. With written authorization we can share your protected health information with anyone you request. You can revoke that right at any time in writing. Additional specific reasonable requests made in writing will be considered.

Link to Health Insurance Portability and Accountability Act (HIPPA) of 1996

https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

Links to Health and Human Services Civil Rights documents

https://www.hhs.gov/civil-rights/for-individuals/index.html

For more information or to make a complaint if you believe your privacy rights have been violated, you can file a complaint with the Department of Health and Human Services Office for Civil Rights at www.hhs.gov or you may email OCR at OCRMail@hhs.gov or call the U.S. Department of Health and Human Services, Office for Civil Rights toll-free at 1-800-368-1019. There will be no retaliation for filing a complaint.

Please complete all fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until canceled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA
☐ Debit Card ☐ Credit Card

Cardholder Name (as shown on card):_____________________________________

Card Number:
____

Expiration Date (mm/yy): ______________
CVV#:______________________

Cardholder Billing Address:
____

____

I, ______________________________, authorize RENEW PHYSICAL THERAPY & PILATES to charge my credit / debit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature________________________________
Date___________________________