



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

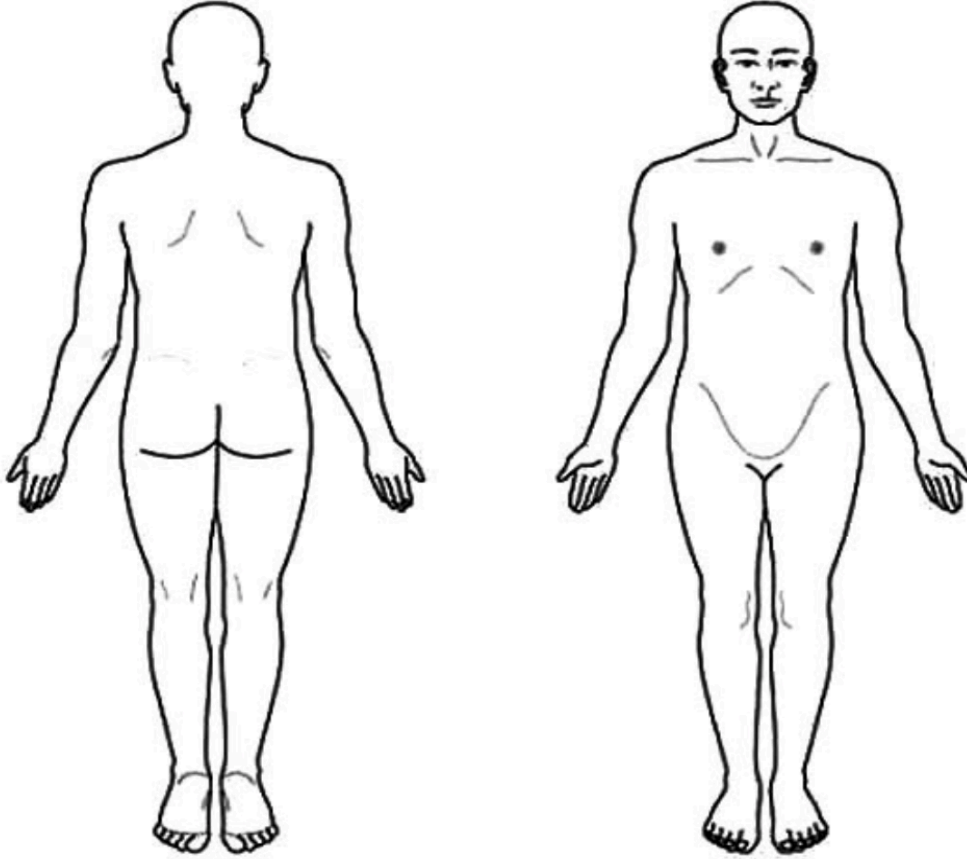
Number of pregnancies: _____ Vaginal or Cesarean delivery (circle)

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 |
| Circulation Issues | Joint Replacement | Thyroid Problems |
| | Kidney Disease | Varicose Veins |

If any are circled, please explain: _____

Please mark any areas of symptoms in your body



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): _____

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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: _____



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 _____



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 (HIPAA) 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.