

NEW CLIENT/PATIENT INFORMATION

Contact Information	Name		Age	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Home Phone:	Best phone number to reach me:		Email*		
	Street Address			City	State & Zip	
	Employer Name			Occupation	Work Phone	
	Emergency Contact Name or Nearest Relative			Relationship	Emergency Phone	
For PT	I will be submitting my receipts to my health insurance or Flexspend? <input type="checkbox"/> Yes <input type="checkbox"/> No		I have a referral from my MD, DC, DO, DPM, etc. for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Referring physician or chiropractor	
How did you hear about us? Circle all that apply: Friend/Family : _____ MD referral _____ Internet Search Newspaper Yelp Facebook/Twitter PhoneBook Golf Pro/Coach/Trainer: _____ Alameda Magazine Alameda Parents Network Other: _____						

**emails are used for appointment reminders, communication between ProBalance practitioners & patients/clients, and for notifications about directly relevant ProBalance services/programs.*

SELF-PAY, FINANCIAL, AND CANCELLATION POLICIES

We take pride in the high-level quality of our services and operate on a different model and level than traditional physical therapy clinics and regular fitness Pilates studios. In order to provide you with the best possible experience, please read the following policies, initial, and sign below to acknowledge our policies.

- ▶ _____(initials) Payment for services is due at the time services are rendered. (Cash, Check, or Credit Card)
- ▶ _____(initials) **A credit card will be kept on file** that is authorized to pay for the day's service, cancellation fees, or for any unpaid balance for your session. **You authorize ProBalance, Inc. to charge your credit card on file for unpaid services received unless prior arrangements have been made in writing.***
 * _____(initials) In the event you choose *not* to keep a credit card on file, you may make a payment in person or by phone. *However, if we do not receive payment on the day of service, you may be charged an additional \$35 late payment fee on top of the balanced owed.*
- ▶ _____(initials) Returned checks and balances older than 30 days may be subject to additional administrative fees, collection fees, and interest charges of 3% per month.
- ▶ _____(initials) A minimum cancellation fee of 50-100% of the price of the visit will be charged for cancellations/no shows less than 24 hours advance notice for appointments. *Note: exceptional circumstances will be considered.*
- ▶ _____(initials) Unused wellness/fitness packages are cash refundable within 14 days of purchase; otherwise, they may be ONLY be exchanged for service credit to your ProBalance account. **There is a \$35 administrative fee per package for exchanges of any package once at least one session has been used from that package.*
- ▶ _____(initials) All wellness/fitness packages have expiration dates. All class packages have an expiration date of 6 months from first use and all private fitness/wellness sessions expire 12 months from first use.
- ▶ _____(initials) Wellness/Fitness/Preventative services (classes &/or private sessions) performed by physical therapists may NOT be submitted to health insurance or Medicare for reimbursement.

I have read and agree to the policies mentioned above.

 Patient Name Signature _____/____/20
 Today's Date

Pre-Screening Health Questionnaire

1. What are your goals? (i.e. why are you here, what activities would you like to return to or improve, etc.)

2. Do you have pain or a physical condition which is currently limiting you? Yes No (if no, skip to #4)
 2a. When did this problem/pain first begin? _____
 2b. Are you currently under the direct care of a medical professional? No Yes (who) _____
 2c. Recent Surgery Date? _____ What Procedure? _____

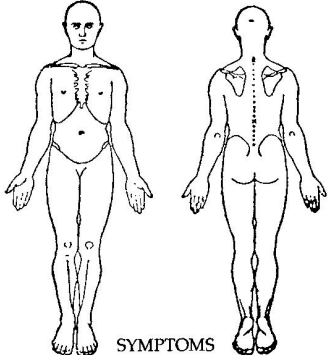
3. Indicate on the chart to the right if you are experiencing any pain/symptoms.

3a. Do you have any numbness or tingling? Yes No
 3b. Do you have pain with coughing/sneezing? Yes No
 3c. On a scale from 1 to 10, my worst recent pain has been ___/10.
 Mild discomfort Moderate Unbearable, Severe
 1-----5-----10

3d. I have pain that bothers me:
 constantly most of the time only occasionally once in a while with certain movements

3e. Symptoms are worse with: _____

3f. Symptoms are better with: _____



SYMPTOMS

4. Circle and/or list all medical conditions you have or have had:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis/Osteopenia (low bone density)	<input type="checkbox"/> Currently Pregnant (How many weeks?)
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Osteo-arthritis (degenerative joints)	<input type="checkbox"/> Post-partum <1 yr
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Currently Breastfeeding
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stenosis or Spondylolisthesis	<input type="checkbox"/> Pelvic instability or SI joint problems
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Sciatica or radiating pain down leg	<input type="checkbox"/> Headaches
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiating pain down arm or leg	<input type="checkbox"/> Fractures
<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Herniated Disc (where/when?)	_____
<input type="checkbox"/> Vertigo or Dizziness	<input type="checkbox"/> Neurologic disease or paralysis	_____
<input type="checkbox"/> Other (describe): _____		

5. Have you had any surgeries? No Yes (If yes, list dates/types/details of surgeries below):

Total Hip Replacement(s) _____
 Total Knee Replacement(s) _____
 Spinal Surgery _____
 Shoulder Surgery _____
 C-Section _____
 Mastectomy/lumpectomy _____
 Other abdominal surgeries _____
 Other Upper Extremity Surgeries (hand, elbow, wrist) _____
 Other Lower Extremity Surgeries (hip, knee, foot/ankle) _____
 Other: _____

6. Please list medications and/or alternative remedies or treatments (supplements, etc.) that you are currently using.

8a. Have you done Pilates or another movement focused exercise program before? Yes No

8b. Do you currently exercise on a regular basis? If yes, describe your current workout or exercise routine.

_____/_____/20
 Patient Name Signature Today's Date

NOTICE OF PRIVACY PRACTICES

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

ProBalance, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. We are a teaching facility so there may be students observing treatments for their respective professional programs. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with ProBalance, Inc.

“It is our policy to provide a substitute health care provider, authorized by ProBalance, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Electronic Communication

Much of our communication is via electronic means, including online scheduling software and encrypted electronic charting and storage. Your information is not shared with third parties as is used to facilitate communication between practitioners & clients/patients. Please be assured that every step is taken to ensure the confidentiality of your health information, included password protected computers and accounts in accordance with HIPAA requirements.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Teaching Facility

We are a teaching facility so there periodically may be students observing your session or class. Please be assured that they are required to adhere to this published privacy policy.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership.

In the event that ProBalance, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that ProBalance, Inc. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. Note that there may be administrative/records fees associated with acquisition/copying of records.
- You have the right to inspect and copy your health information.
- You have a right to request that ProBalance, Inc. amend your protected health information. Please be advised, however, that ProBalance, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by ProBalance, Inc..
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

ProBalance, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, ProBalance, Inc. is required by law to comply with this Notice.

ProBalance, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Ada Wells by calling this office at (510) 523-1900. If Ada Wells is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how ProBalance, Inc. has handled your health information should be directed to Ada Wells by calling this office at (510) 523-1900. If Ada Wells is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of July 1st, 2008.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide ProBalance, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice and I have received a copy or have access to an electronic copy of this form.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date

Release of Liability/Informed Consent

I desire to engage voluntarily in ProBalance Inc.'s Physical Therapy/Pilates/Wellness Program(s). In order to attempt to improve my physical condition, I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory and musculoskeletal systems and thereby attempt to improve their function. The reaction of the cardiorespiratory and musculoskeletal systems cannot be predicted with complete accuracy. These changes might include abnormalities in blood pressure and heart rate, injury to the connective tissue and musculoskeletal systems potentially resulting in stroke, heart attack, permanent injury and possibly death.

The use of all ProBalance facilities – exercise equipment including Pilates apparatus, props, weights, treadmills, and stationary cycles– is undertaken by the patient/client at his/her sole risk. The risk of injury from activities involved in this program is significant, including the potential for permanent paralysis and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist.

All of ProBalance Inc.'s Staff/Contractors are professionally licensed or comprehensively trained in their respective fields. I understand that I am responsible for informing ProBalance Representatives/Staff of any known physical limitations, illnesses, or other physical conditions. Should any unusual symptoms occur during my time at the ProBalance Studio facilities, I will inform a ProBalance representative/staff member immediately. In addition, if I experience a change in my physical limitations, illnesses or other physical conditions or become ill outside the ProBalance Studio facility I will inform a representative/staff member of this change prior to resuming treatment and/or workouts on my next visit and/or contact my doctor if the symptoms warrant. I have consulted my physician before participation in these programs and hereby represent to ProBalance, Inc. that I have their approval to engage in such activities.

ProBalance, Inc. is a teaching facility and on occasion, there may be students observing patient/client sessions as it pertains to their educational requirements. There may also be interns and apprentice teachers assisting under the direct supervision of a qualified practitioner.

I willingly agree to comply with the stated and customary terms and conditions for participation. If, however I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest ProBalance representative/staff member immediately

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless ProBalance, Inc., their officers, officials, agents, independent contractors, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event (“Releasees”), with respect to all and any injury, disability, death, or loss or damage to person or property, whether arising from the negligence of the releasees or otherwise, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY/CONSENT FORM AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

 PARTICIPANT’S SIGNATURE

 DATE

Please initial here _____ to indicate that you have received a copy of this consent form or have been informed as to where to find this form on our website at www.ProBalancePT.com.

**FOR PARENTS/GUARDIANS OF PARTICIPANTS OF MINORITY AGE
 (UNDER AGE 18 AT TIME OF REGISTRATION)**

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release, as provided above, of all the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child’s involvement or participation in these programs as provided above, even if arising from their negligence, to the fullest extent permitted by law.

 PARENT/GUARDIAN’S SIGNATURE

 DATE

EMERGENCY PHONE: _____ Relationship _____
 ProBalance, Inc. * www.ProBalancePT.com * 510-523-1900