BODY TEMPLE PHYSICAL THERAPY, INC.

Licensed Physical Therapist
Certified Athletic Trainer
Certified Strength & Conditioning Specialist

Private Physical Therapy ♦ Personal Training ♦ Yoga Therapy ♦ Wellness

CONSENT FOR PHYSICAL THERAPY

Please print all pages, fill out, sign and return, prior to your online appointment, or bring it with you to, your first in-person appointment (whichever is first).

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended physical therapy service to be provided so that you may make the decision whether or not to receive services after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to the services.

By signing this form, I voluntarily understand, acknowledge, and agree to the following with respect to physical therapy services rendered by Body Temple Physical Therapy, a California professional corporation, and their employees (including Liz Duncanson ("Physical Therapist")), associates, technical assistants, agents, and other healthcare providers (collectively "Company" or "Body Temple Physical Therapy, Inc." or "Body Temple PT").

1. **Physical therapy Services.** Body Temple Physical Therapy, Inc. provides physical therapy services in a holistic, integrative, and therapeutic way. Body Temple Physical Therapy, Inc. integrates its physical therapy services with yoga, personal training, athletic training, Pilates, acupressure, and other healing modalities and techniques. Body Temple Physical Therapy, Inc. teaches patients to become self-aware and discover how to navigate the connections between body, mind and spirit. Services may be provided virtually and in some cases may be in person.

2. **Referrals.** In California, physical therapists can see you with or without a medical referral, for wellness and fitness purposes, and for an initial physical therapy evaluation. For physical therapy treatment of an injury, you can receive direct physical therapy treatment services for a period of up to forty-five (45) calendar days or twelve (12) visits, whichever occurs first. To continue to receive physical therapy treatment, you will need to receive, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

2. **Payments for Services.** Physical therapy services will be billed directly to the patient and full payment is due at the time of the service. We are not a participating provider for any insurance plans. Please find as Addendum A Body Temple Physical Therapy, Inc.'s Rate Sheet, which is attached and incorporated by reference.

3. **No Participation in Insurance Plans.** Body Temple PT is an out-of-network provider for services within this physical therapy practice; Body Temple PT does not participate in any insurance panels, and does not accept assignment from any insurance company. Consequently, I am responsible for payment in full at time of service and charges are determined by Company.

4. **No Responsibility to Determine Eligibility for Benefits.** Body Temple PT is not responsible for determining eligibility for benefits or for assisting me with collecting insurance benefits and has no responsibility to correspond with or telephone or email any insurer with which Body Temple PT is an out-of-network provider.

5. **My Financial Responsibility.** Body Temple PT may provide me with an itemized statement (or "super-bill") to present to my insurance carrier. However, I am financially responsible for any charges for services even should my insurer determine that those services are non-covered or are unreasonable, medically unnecessary or inappropriate. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Body Temple PT to take action to secure payment of an outstanding balance.

6. **Medicare.** In order for a patient who has Medicare to be treated by Body Temple Physical Therapy, Inc. ("Body Temple PT") the patient must first verify:
    a) Services are non-covered because they are not defined as a Medicare benefit under the statute;
    b) Services are non-covered because they are not considered "reasonable and necessary";
    c) Services that may be a Medicare benefit are not covered because coverage requirements are not met and would cause a technical denial.

4. 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. **Body Temple PT's services non-covered by Medicare or Medi-Cal are billed to the patient and that full payment is due at the time of service.**

5. **Cancellation Policy.** Body Temple PT requires that appointment cancellations be made within 24 hours. If I cancel my physical therapy appointment or no-show, I agree to pay a **cancellation/no-show fee** for the full price of the service for which I

was scheduled. This no show charge will not be covered by insurance and will need to be paid out of pocket and I agree to Body Temple PT charging this cancellation/no-show fee to my credit card on file.

6. **No Refunds.** Body Temple PT does not offer any refund for office visits or services of any kind.

5. **Informed consent for treatment.** The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained.

6. **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. Benefits are not guaranteed nor guaranteed to be permanent.

7. **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 within 24 hours, I agree to contact my physical therapist. Other risks include, but are not limited to, swelling, edema, dizziness, fainting, nausea, falling, cardiovascular problems including heart attack, chest pain, and problems breathing. Also, I may experience or incur new injuries during physical therapy; if it does not subside within 24 hours or if it is a serious injury then I agree to contact my physical therapist and seek immediate medical treatment if required or if I experience a serious symptom such as chest pain or heart attack.

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. **Body Temple PT 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. **Consent to Treat.** I hereby give authorization for the performance of such rehabilitation procedures as permitted by the State of California, Department of Consumer Affairs, Physical Therapy Board under the California Physical Therapy Practice Act (Cal. Bus. & Prof. Code, sections 2600 et al.) and relevant sections of the California Code of Regulations (16 Cal. Code Regs., sections 1398 et al.) under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.

10. **Consent to Observation.** Body Temple PT is a teaching facility. All patient care is overseen and supervised by an attending physical therapist. Prospective students and students of physical therapy may observe examinations or treatment of patients as a part of the health care education programs of the institution. Each student or observer will abide by all privacy practices of Body Temple PT and HIPAA rules and regulations. Prior to observation, attending Physical Therapists will obtain each patient's consent (either verbally or in writing) to the presence of the Student or Observer and document such consent in the patients' health record.

11. **Consent to Telehealth**. Body Temple PT provides physical therapy services through online video conferencing software. This is defined as "telehealth", which involves the delivery of clinical health care services by electronic communication (including two-way audio-visual communication), as defined by applicable law. Use of telehealth services by Body Temple PT can result in benefits such as improved access to care. Potential risks include gaps of failures in communication, complicating healthcare decision-making, notwithstanding reasonable efforts to ensure the quality and reliability of transmitted information. There may be limitations to image quality or other electronic problems that are beyond the control of the healthcare provider. Despite reasonable security measures, online communications can be forwarded, intercepted, or even changed or falsified without my knowledge. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. I understand and agree to participate in telehealth services.

12. **Disclosure of Conflicting Interests**. I understand that Body Temple PT makes available products and medical devices for sale to patients by purchasing them online through a link on Body Temple PT's website. This is because Body Temple PT believes it can identify products that that have quality of science behind them and/or experience working with the product(s). Further, with regard to the sales of these products and/or medical devices, there is a retail price which typically includes a usual and customary markup and Body Temple PT has a financial interest in sales of these products, although I will never pay more than retail price for such product(s) or medical device(s). I understand that **I am not obligated to purchase these products, and can purchase these products and/or medical devices from any source of my choosing**. I understand that the physical therapy services I am offered will not be affected if I choose to purchase similar products elsewhere.

13. **My Participation**. I understand that Body Temple PT and I are to work as a team on my overall wellness. This requires me to be an active participant for best outcomes, I am responsible to disclose to Company all medication, care, treatment, diagnoses, and assessments that I receive elsewhere and to provide

medical records from other providers to ensure that care is coordinated and compatible. Medical records can only be released with my authorization. I will need to obtain any records that I would like Body Temple PT to review.

14. **No warranty**. My physical therapist at Body Temple Physical Therapy, Inc. 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. **My physical therapist at Body Temple PT cannot and will not make any promises or guarantees regarding a cure for or improvement in my condition.**

15. **Assumption of Risk; Indemnity.** I choose to receive care that involves clinical innovation and/or differs from conventional, cookbook physical therapy; accordingly, I knowingly, voluntarily, and intelligently assume risks involved in the same. As a result of my assumption of these risks, I agree to release, hold harmless, indemnify, and defend Body Temple PT from and against any and all claims which I (or my representatives) may have for any loss, damage, or injury arising out of or in connection with use of the services described above, or arising out of or in connection with referral to other practitioners or merchants for delivery of any services. Correspondingly, I agree not to pursue a claim against any of the foregoing, merely because I am dissatisfied with the results of the above services

16. **Arbitration.** Any dispute arising out of or relating to this contract or the subject matter thereof, or any breach of this Agreement, including any dispute regarding the scope of this clause, will be resolved through arbitration administered by the American Health Lawyers Association Dispute Resolution Service and conducted pursuant to the AHLA Rules of Procedure for Arbitration. Judgment on the award may be entered and enforced in any court having jurisdiction. The Arbitration shall be held in Walnut Creek, California. The arbitrator(s) shall apply the substantive law of the foregoing state, or federal substantive law where state law is preempted. The arbitrator(s) shall have the power to grant all legal and equitable remedies provided by law and award compensatory damages provided by law, except that punitive damages shall not be awarded. The arbitrator(s) shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based. The arbitrator(s) shall not have the power to commit errors of law or legal reasoning. Any judicial review of the arbitrator(s) decision shall be governed by the foregoing state's law. HOWEVER, prior to either party initiating Arbitration of any dispute, the parties agree to attempt mediation of the dispute with a mutually agreeable trained mediator in the above-mentioned city or county. EACH PARTY HAS READ AND UNDERSTANDS THIS SECTION, WHICH REQUIRES THE PARTY TO SUBMIT ANY CLAIMS TO ARBITRATION, AND WHICH WAIVES THE PARTY'S RIGHT TO A JURY TRIAL.

THE UNDERSIGNED ACKNOWLEDGES HAVING READ AND UNDERSTOOD THE ABOVE INFORMATION, WHICH IS PRINTED IN ENGLISH, AND ACKNOWLEDGE THAT ENGLISH IS A LANGUAGE I READ AND UNDERSTAND, AND THAT I UNDERSTAND THE FORM. THE UNDERSIGNED HEREBY CONSENTS TO PHYSICAL THERAPY EVALUATION AND TREATMENT BY BODY TEMPLE PHYSICAL THERAPY, INC. THE UNDERSIGNED ALSO ACKNOWLEDGES HE OR SHE WILL ABIDE BY THE CONDITIONS AND POLICIES NOTED ON THIS CONSENT FORM. I DO NOT FEEL RUSHED OR IMPAIRED, NOR AM I UNDER THE INFLUENCE OF A SEDATIVE OR SLEEP-INDUCING MEDICATION.

I AM FREE TO REFUSE OR WITHDRAW MY CONSENT AND TO DISCONTINUE PARTICIPATION IN ANY TREATMENT OR SERVICE AT ANY TIME WITHOUT FEAR OF REPRISAL AGAINST OR PREJUDICE TO ME. NO REPRESENTATIONS, STATEMENTS, OR INDUCEMENTS, ORAL OR WRITTEN, APART FROM THE FOREGOING WRITTEN STATEMENT, HAVE BEEN MADE. I MAY REQUEST AND RECEIVE A COPY OF THIS FORM FROM BODY TEMPLE PHYSICAL THERAPY, INC. IF ANY PORTION OF THIS FORM IS HELD INVALID, THE REST OF THE DOCUMENT WILL CONTINUE IN FULL FORCE AND EFFECT.

_____

Name (Please Print) Signature Date

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

_____

Name (Please Print) Relationship (if applicable) Signature Date

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Client Evaluation Initial History Intake
Protected Health Information (PHI)

Name:_____ Date: _____

Your pronouns: They/Them; She/Her; He/His; Decline to State; Other: _____
Gender Identity: Non-Binary / Trans Female / Cis Female / Trans Male / Cis Male/ Decline to State; Other:_____

Age: _____ Date of Birth: _____

Occupation: _____

Employer: _____

Primary Care Physician: _____

Health Insurance: _____

Hobbies/Sports: _____

Address: _____

_____

Phone: (_____)_____

Cell: (_____)_____

Email: _____

Marital Status: _____

Emergency Contact's Name / Relationship: _____

Emergency Contact's Telephone: _____

Are you a caregiver for dependents?
Yes No
If yes, how many children? ___ If yes, how many adults? ___

Were you referred to *Body Temple PT* by anyone? If not, how did you hear of us?

_____

If you would like an occasional email with workshop offerings and studio updates, please circle: Yes

What services attracted you to Body Temple? (check all that apply)
_____ Traditional Physical Therapy Evaluation and Treatment
_____ Manual Body Work including joint and tissue mobilization (“PT Massage”)
_____ Personal Training/Strength and Conditioning and Athletic Training
_____ Yoga and Pilates

What brings you to seek treatment at Body Temple PT and what is your primary complaint? Please briefly describe:

If different, Please describe your current health concern(s) and roughly when it/they began - in order of priority:

Health Concern	When it began:
1.	
2.	
3.	

Please rate your current symptoms/difficulties for which you are presenting with today:
0 = Not difficult / 10 = Unbearable

0 1 2 3 4 5 6 7 8 9 10

How do these symptoms/difficulties impact your quality of life?

What do you believe is causing your most important health concerns?

Please list any previous surgical procedures and any details/hardware (ie: prosthesis, wires, internal pins/fixators):

Is this an injury that needs treatment? Please circle: Yes or No

Is this the result of a car accident or high impact injury? Please circle: Yes or No
If yes, what was the date of the accident: _____

Are you getting better, worse, or staying the same since your onset of symptoms?
Please circle: Better, Worse, or Same

Have you seen a physician for this problem? Please circle: Yes or No

If yes, did your physician instruct you to see a physical therapist? Please circle: Yes or No

If yes, what diagnosis and ICD10 Code did your physician assign for the referral?

_____

Have you had any tests (X-ray, MRI, CT Scan, Doppler, ultrasound, etc.) to discover or treat this issue? Please circle: Yes or No

If yes, please list tests and their results here:

Have you had any prior treatment for this condition or injury, such as PT, massage, Acupuncture, etc.? Please circle: Yes or No

If yes, please describe:

What are your physical goals with therapy? Please list:

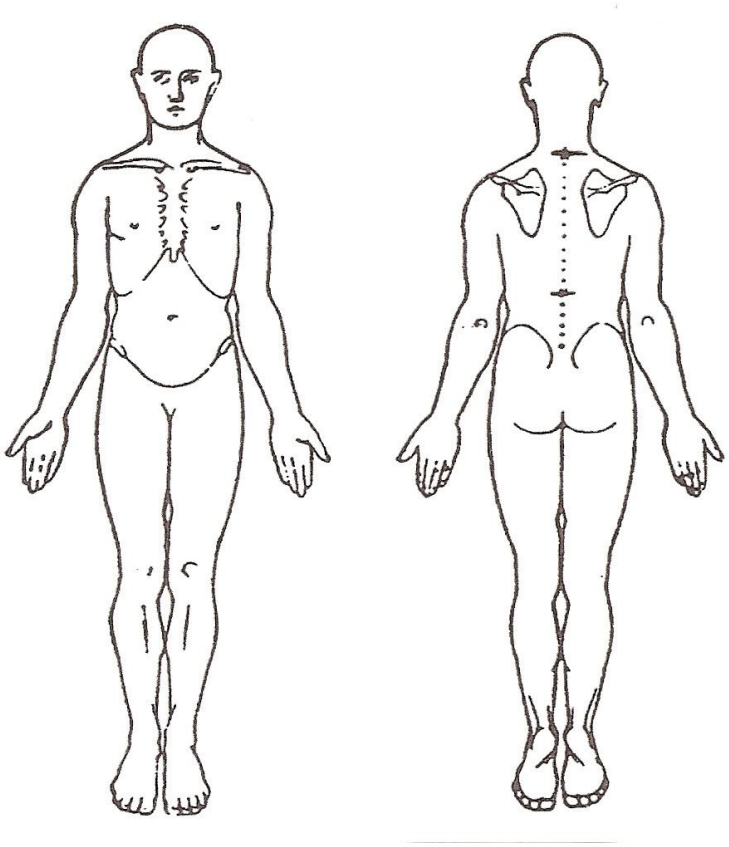
What aggravates, exacerbates, or worsens your symptoms or injury?

What eases or improves your symptoms?

Please list ALL current medications and *circle any that are specifically for this current injury:*

What are your physical and functional limitations? Are you able to completely participate in your usual daily activities such as computer work, housework, stair ambulation, etc., due to your current injury/condition?

Please indicate and describe your symptoms on the body figures below:



Have you EVER had any of the following conditions?

Please circle Yes or No and if yes please indicate year of incidence:

Yes	No	Bowel/bladder incontinence (involuntary leakage of urine or feces)
Yes	No	Diabetes
Yes	No	Hypertension (High Blood Pressure)
Yes	No	Cardiac (Heart) Problems or Stroke
Yes	No	Dizziness or Vertigo
Yes	No	Numbness or Tingling
Yes	No	Osteoporosis/Osteopenia
Yes	No	Sudden weight loss >50 pounds for no reason

Yes No Pain in your back or neck with coughing or sneezing
Yes No Night Sweats
Yes No Cancer
Yes No High Cholesterol
Yes No Frequent Headaches/Migraines
Yes No Fibromyalgia, Chronic Fatigue
Yes No Other Autoimmune Conditions or Deficiency
Yes No Allergies to Wool, Latex, or Tree Nuts
Yes No Skin Sensitivity
Yes No Smoker
Yes No Asthma
Yes No Circulation Issues, Bruise or Bleed Easily, or Fragile Skin
Yes No Fractures
Yes No Hepatitis
Yes No Heartburn
Yes No Metal Implant
Yes No Pacemaker
Yes No Stroke
Yes No Motor Vehicle or Other High Impact Accident
Yes No Surgery

If yes, please list dates and procedures:

_____

(Please continue on the back if necessary)

Yes No Anything else that affects your medical history

If yes, please explain: _____

(Please continue on the back if necessary)

Have you been experiencing any of the following issues in the last 3 - 6 months?

Yes No Breathing Problems
Yes No Vision Problems
Yes No Tiredness/Fatigue
Yes No Fever or Chills
Yes No Night Sweats or Hot Flashes
Yes No Insomnia
Yes No Nausea
Yes No Pain that wakes you at night

Yes	No	Are you pregnant or recently postpartum?
Yes	No	Experiencing weakness in a limb?
Yes	No	Swelling or Edema?
Yes	No	Change in Bowel Movements
Yes	No	Persistent Joint Pain
Yes	No	Difficulty Concentrating or Memory Issues
Yes	No	Muscle Spasms
Yes	No	Eating Disorder or Difficulty. Anorexia or Bulimia
Yes	No	Difficulty Sleeping
Yes	No	Depression or Anxiety

Dental History

Yes	No	Have you ever worn braces or retainer?
Yes	No	Do you grind or clench your teeth?
Yes	No	History of TMJ Disorder?
Yes	No	Currently wearing a night guard?
Yes	No	Experience Clicking, or Locking, in your jaw?

Please describe your own birth (Forceps, Natural, C-section) _____

Have you ever been or are you now in an abusive relationship (were you are or were physically or emotionally threatened, insulted, beaten, injured or made to take part in sexual activities against your will)? Please circle: Yes or No

Do you smoke? Please circle: Yes or No
If yes, what? How much per day? Since when?
Do you drink alcohol? Please circle: Yes or No
If yes, what? How much? How often?
Do you drink soda? Please circle: Yes or No
If yes, what type?
Regular soda Diet soda
How much? How often?
Do you drink caffeine? Please circle: Yes or No
How much per day?
How much water do you drink daily?

Do you exercise regularly?
If yes, please describe what activity you participate in.

What activities or hobbies bring you joy?

Please list some typical items from your daily diet:

How is your sleep quality? Please Circle: Excellent Good Fair Poor Terrible
And how many hours per night do you sleep?

Do you have any of the following sensitivities?
Light Sound Smell Heat Cold Other

Emotional stress scale: 0 - No stress / 10 - Extremely stressed
0 1 2 3 4 5 6 7 8 9 10

Please check the box that best describes your outlook in the past month:

Strongly Disagree Disagree Neutral Agree Strongly Agree

I balance work, school, family, self
Strongly Disagree Disagree Neutral Agree Strongly Agree
I make time for leisure pursuits.
Strongly Disagree Disagree Neutral Agree Strongly Agree
I feel good about myself
Strongly Disagree Disagree Neutral Agree Strongly Agree
I am happy with my life.
Strongly Disagree Disagree Neutral Agree Strongly Agree
My life has meaning and purpose.
Strongly Disagree Disagree Neutral Agree Strongly Agree
I look forward to growing and changing.
Strongly Disagree Disagree Neutral Agree Strongly Agree
I make time for self-reflection (affirmations, prayers, meditation)
Strongly Disagree Disagree Neutral Agree Strongly Agree
I have a vision for my life
Strongly Disagree Disagree Neutral Agree Strongly Agree

What are your top three goals/intentions for coming to see me?
1.
2.
3.

Who in your circle of family or friends will support you with health and lifestyle changes?

Anything else I should know about your health or expectations?

FOR WOMEN ONLY

Please list: Number of Pregnancies ____ Children ____
If children, Full Term Delivery methods (vaginal/c-section/v-bac)
_____

Date of last pelvic exam_____ and Pap Smear Test: _____ neg or positive?

Please circle Yes or No and if yes please indicate year of incidence:

Yes	No	Irregular Menstrual Cycle
Yes	No	Pain and Cramping During Period
Yes	No	Pain with intercourse
Yes	No	Difficult Pregnancies or Deliveries?
Yes	No	Multiple gestation/twins? _____
Yes	No	Pelvic or Abdominal Tearing? Stitches?
Yes	No	Cesarean Section
Yes	No	Membrane Ruptures?
Yes	No	Pre-eclampsia/Toxemia? (High Blood Pressure During Pregnancy)
Yes	No	Gestational Diabetes?

COVID-19 WAIVER

By signing this form, I acknowledge that, with respect to services rendered Body Temple Physical Therapy, a California professional corporation, and their employees and agents (collectively "Company"), I understand the following:

Coronavirus (COVID-19) Risks

I understand that I am opting for a non-essential service which is not urgent and may not be medically necessary. I also understand that the novel Coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization and Centers for Disease Control. I further understand that COVID-19 is extremely contagious and is believed to be spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing, wearing a face mask or covering, and frequent washing of hands and surfaces.

I understand that Company has put in place reasonable and preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by proceeding with receiving physical therapy services. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through receiving these services, and I give my express permission for Company to proceed.

I understand that, even if I have been tested for COVID and received a negative test result or positive anti-body test result, the tests in some cases may fail to detect the virus or may produce a false positive antibody. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms, proceeding with receiving services can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before, during, and after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine or self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation or ventilator support, short-term or long-term intubation other potential complications, and the risk of death. In addition, after receiving my services, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for receiving these services.

I have been given the option to defer receiving these services to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with receiving Company's services.

I have carefully read this form, which is printed in English, and acknowledge that English is a language I read and understand, and that I understand the form. I do not feel rushed or impaired, nor am I under the influence of a sedative or sleep-inducing medication.

I accept and agree to all of the terms above. I am free to refuse or withdraw my consent and to discontinue participation in any treatment, service, or research at any time without fear of reprisal against or prejudice to me. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. I may request and receive a copy of this form from Company. If any portion of this form is held invalid, the rest of the document will continue in full force and effect.

Patient (signature required)				
Signature				
Name				
Date		Time		(AM/PM)
Fill out below if someone other than the patient is signing this form.				
Signature				
Name				
Title/Relationship to Patient				
Authority to Sign Document				
Date				
Witness Name (optional)				
Signature				
Date				