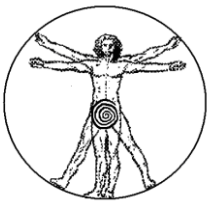

Wholistic Physical Therapy, P.C.

INITIAL INTAKE FORM

Please fill this out before your appointment. Scan or fax it over to us, or hand deliver at your first appointment!

Personal Information ***(Please print clearly)***

Name: _____
last first middle initial

Home Address: _____
street city state zip

Telephone: Home: (____) _____ Mobile: (____) _____ Work: (____) _____

Social Security # : _____ Date of Birth: _____ Age: _____ Sex: _____

Marital Status: S M W D Spouse's name:_____ E-Mail address: _____

Nearest Relative *(other than spouse)* emergency contact : _____

Telephone: Home: (____) _____ Relationship: _____

Medical Information

Diagnosis: _____

Primary Physician: _____

Referring Physician: _____

Who referred you to our clinic *(if other than your Physician)*: _____

Insurance Information ***(Please provide card(s) for photocopy)***

Primary Insurance carrier: _____

Secondary Insurance carrier *(if applicable)*: _____

Assignment and Release

Patient is responsible for payment in full at the end of each session

I, the undersigned, certify that I (or my dependent) have insurance as stated above and assign directly to Wholistic Physical Therapy all insurance benefits for my treatments. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize WPT to release all information necessary to secure the payment of benefits. I allow fax transmittal of Medical records if necessary. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and/or Health Insurance Company.

- I consent to the treatment necessary for the care of the above-named patient/client.
- I acknowledge full financial responsibility for services rendered by Wholistic Physical Therapy and their staff and understand that the payment of charges incurred is due at the time of the service.
- I have read and fully understand the consent to treat, financial responsibility, and release of medical records information.

Responsible Party's Signature Relationship Date

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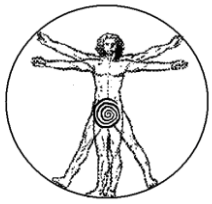
And 18 E 41st Street (ste 406), New York, NY 10017
Phone: (845) 940-1050 Fax: (845) 940-1051 E-mail: administrator@wholisticphysicaltherapy.com



Wholistic Physical Therapy, P.C.

WELCOME

We would like to take this opportunity to thank you for choosing us, we look forward to assisting you in your healing process. Please print, read, fill out, initial and sign where applicable, the pages in this packet. Then scan/email or fax it over to us ideally; or hand deliver it at your first visit.

We aim to provide the expertise, guidance, environment and therapeutic treatment to help you achieve your goals and enhance your ability to return to a pain-free, active lifestyle.

People are referred to the Myofascial Release Treatment Center from a wide geographical area, for the resolution of complex problems that have failed to respond to conventional medications, surgery, and therapeutic treatments. Physical Therapy is dedicated to the comprehensive delivery of the highest quality care utilizing a multifaceted, multidisciplinary approach for lasting results.

Other than Medicare, we are not contracted with any insurance companies. However, the payments you make are reimbursable by your insurance company under your out of network physical therapy benefits. The exact percentage depends upon your plan. We will assist you in every way possible. Unless you are a Medicare beneficiary, payment is due at the time of service. Fees are assessed hourly and are $175 in Brewster, $250 in Manhattan, per hour. Please allow us to make copies of your insurance card(s).

We request that all clients extend a courteous 24-hr cancellation notice to change or cancel any 1 hour appointment and 48-hr cancellation notice to change or cancel any 2 hour appointment. If less than 24-hr or 48-hr notice is given, the session fee will apply in a discretionary fashion.

Office hours (subject to change): Monday 11am to 8pm, Wednesday from 9am to 8pm. Tuesday, Thursday and Friday from 9am to 5pm. We would appreciate your cooperation and courtesy in keeping your scheduled appointment times as well as notifying us of any delays.

Please note that e-mail addresses and contact information will be used only to forward educational material and for professional reasons. All your information record is held in the utmost confidence.

If photographs are taken during initial evaluation, progress evaluation and discharge summary, they will be used for postural comparison purposes and as educational tools. By signing below, you consent to the use of these photographs in a professional manner.

I have read and understand the above office policy. I hereby agree to pay directly this office for professional services rendered and shall be personally responsible for any unpaid balance to this office. I hereby authorize the attending therapist to release any information concerning my examination or treatments to my insurance carrier or other medical professionals involved in my care.

Patient Name: _____

Signature: _____ Date: _____

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Wholistic Physical Therapy, P.C.

TERMS & CONDITIONS

Please read and initial all the below:

Confirming that you understand and agree to the terms and conditions of our Terms & Conditions.

_____ **Insurance** In order to maintain our high standard of care WPT does not participate in network with insurance plans. WPT will bill your insurance company, for you electronically if you ask, or provide you an invoice for you to submit to them yourself. We do accept all out-of-network Physical Therapy policies depending on if your insurance policy has an out of network benefit. Please make sure that we have all your current information.

_____ **Responsibility:** Please be aware that your insurance company may only cover a portion of your service. You, the client/patient will be responsible for the difference.

_____ **Rx:** Within your first 30 days at WPT, we must have a copy of the prescription from your doctor, this is state law. We suggest having a prescription from the outset to ensure coverage, not guaranteed.

_____ **Medicare**: WPT is a participating provider for Government Medicare. WPT will bill Medicare directly. The Client/Patient is responsible for any deductible remaining at the time of service, unless, you have a secondary insurance. If not, a 20% co-payment will be collected from you at the time service is rendered. Please be aware, there is a cap/maximum allowable amount on all Medicare allowable claims.

_____ **Automobile Accidents**: WPT will bill your Auto Insurance only under PIP benefits. WPT may, on a case by case basis, accept assignment on any automobile accident. We may, on a case by case basis, accept settlement from attorneys or wait for settlement from any automobile carriers. WPT maintains the right to select these cases.

_____ **Durable Medical Equipment** (DME) and Supplies: DMS and Supplies are not Reimbursable by insurance companies if sold from WPT and must be paid for at the time you receive such equipment. Items like a theracane, ball, foam roller etc.

_____ **Payment** is expected when services are rendered (each visit). For your convenience, we Accept checks, cash, and credit Cards.

_____ **Late Charges/Returned Checks:** Any account that remains open beyond 30 days from the Last date of service will be subject to a $10.00 fee for each month that the account is not paid in full. There is a $35.00 fee for all returned checks.

_____ **CANCELLED/MISSED APPOINTMENTS:** Late arrivals are subject to the full fee for the Session. We require 24 hours notice for all cancellations. All appointments that are cancelled within less than 24 hours notice or "no-show" are subject to at least a $50.00 fee for the session, up to full fee. With 2 missed appointments, either cancelation or no-show, WPT reserves the right to cancel all remaining appointments.

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Wholistic Physical Therapy, P.C.

CONSENT FOR TREATMENT

The patient hereby consents to the administration of appropriate Physical Therapy evaluation and therapeutic treatment/procedures as recommended by the therapist and as requested by the patient and/or physician prescribing physician.

Patient Signature_____ Date: _____

OUR PLEDGE REGUARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at WPT. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by WPT. We are required by law to:

a. Make sure that medical information that identifies you is kept private.

b. Give you this notice of our legal duties and privacy practices with respect to medical information about you.

Patient Signature_____ Date: _____

MINOR POLICY

If Patient/Client is under 18 years of age, and a parent is not available to attend sessions of Physical Therapy with the minor, the Parent(s) signature for authorization allows WPT to commence Physical Therapy with the patient who is a minor. The parent(s) is also accepting full financial responsibility for the treatment.

Parent's Signature_____ Date: _____
(If patient/Client is under 18 y/o)

We believe in an integrated, Wholistic, whole-person approach. Therefore, the following pages of health information specific to you is being requested to aide us in providing you with the most informed care and highest quality of service. The therapist will discuss these and more with you during the initial consultation to best understand your situation and tailor treatment goals specific and individualized to you.

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Wholistic Physical Therapy, P.C.

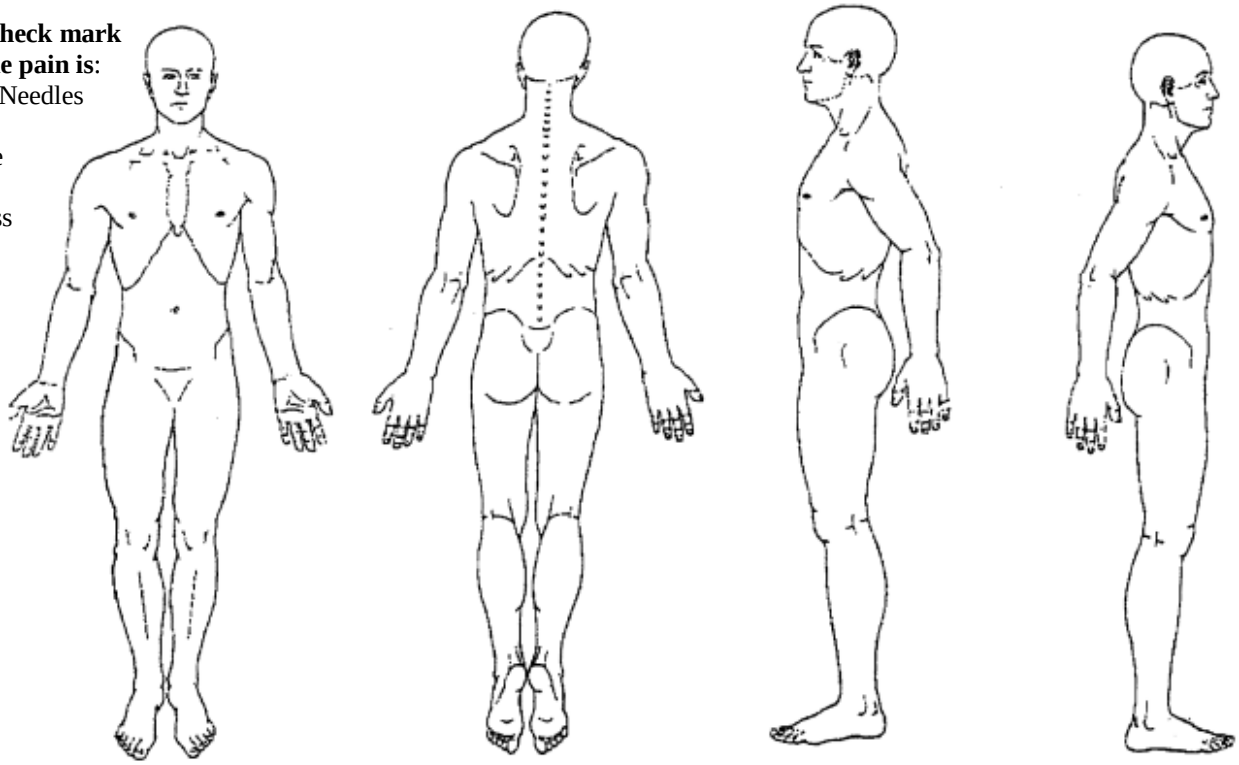
MEDICAL HISTORY

Patient Name: _____

Please circle if you have had any of the following:

Yes/No High blood pressure	Yes/No Arthritis
Yes/No Heart disorder	Yes/No Circulation disorder
Yes/No High cholesterol	Yes/No Dizzy spell
Yes/No Lung disorder	Yes/No Seizures
Yes/No Depression	Yes/No Chronic pain
Yes/No Chronic fatigue	Yes/No Cancer
Yes/No Pacemaker	Yes/No Osteoporosis
Yes/No Allergies to lotions	Yes/No Are you pregnant?
Yes/No Diabetes	Yes/No Gastrointestinal disorder
Yes/No Anxiety disorder	Yes/No Headaches

Place a check mark where the pain is:
Pins and Needles
Stabbing
Dull ache
Burning
Numbness



Please circle where you are having pain.

Is the pain constant/intermittent? Does the pain radiate? Where? Please describe the pain:

_____

_____

What makes it feel better? _____

What makes it feel worse? _____

Rate the pain intensity on a scale of 1-10 (10 the worst pain): please circle

0 1 2 3 4 5 6 7 8 9 10

No pain Excruciating pain

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Please list any significant hospitalizations and surgical procedures/reasons/dates please. Scar tissue can cause pain and dysfunction in the body. Please list all surgeries you have had, including cosmetic:

_____

_____

Please list any medications that you are presently on:

Medication	Dosage	Frequency	Start Date	Purpose	Prescribing MD

Do you smoke?____cigar/cigarettes/pipe?____ How much? _____When did you quit?_____

What, if any, recent diagnostic studies have you had? (MRI, Doppler, X-ray, etc)

_____

_____

History of current condition, including onset date.

_____

_____

_____

Previous care you have received (physical therapy, chiropractic, acupuncture, injections, etc)

_____

_____

_____

At the present time, would you rate your overall general health as? Circle one:

Excellent Good Fair Poor

And how would you describe your overall diet?

_____

_____

Circle if you include in your diet the following: Alcohol Dairy Meat Gluten/Wheat

Approximately how many servings of Fruits and Vegetables do you eat per day? 0-2 2-5 5-9 9+

Approximately how many oz water do you drink per day?: _____

Is there anything else you would like us to know?

_____

_____

Patient Initials: _____

Wholistic Physical Therapy, P.C.

FUNCTIONAL ASSESSMENT

Answer the following questions, *if applicable*:

1. Do you find it difficult to change positions? Please describe _____
   _____
   _____

   Do you find it difficult to lie down? Yes_____ No_____

   To come to a sitting position from lying down? Yes_____ No_____

   Do you have trouble getting up from a chair? Yes_____ No_____

2. Do you have trouble putting on your shoes and socks? Yes_____ No_____

3. I walk for _____minutes before needing to rest.

4. I stand for _____minutes before needing to sit.

5. I sit for _____minutes before needing to change positions/get up

6. Do you have difficulty stairclimbing? Yes_____ No_____

7. How often during the day do you need to lie down and rest?_____

8. Do you engage in regular exercise? Yes_____ No_____ What type and how often?
   _____
   _____

   Are you able to exercise now? Yes_____ No_____

9. Do you have discomfort, shortness of breath or pain with exercise?_____

10. Do you work? Yes_____ No_____ What is your Occupation?_____

11. In general, your lifestyle is: 1 2 3 4 5
    active average inactive

12. WHAT ARE YOUR GOALS FOR THERAPY? _____
    _____
    _____

I UNDERSTAND THE TREATMENT PLAN WILL BE OUTLINED AND EXPLAINED TO ME BY THE PHYSICAL THERAPIST AND I CONSENT TO THE TREATMENT.

Signature Date

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Wholistic Physical Therapy, P.C.

A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS

I authorize the holder (WPT) of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. Furthermore, I request that payment under the medical insurance program be made to me or to Wholistic Physical Therapy. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize the holder of medical information about me to release it to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I understand that this is a lifetime signature authorization.
I request that payment of authorized MEDIGAP benefits be made on my behalf to Wholistic Physical Therapy, for any services furnished me by (physician/supplier). I authorize any holder of medical information to release to Wholistic Physical Therapy, any information needed to determine these benefits or the benefits payable for related services.

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I authorize Wholistic Physical Therapy to release to your company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Physical Therapeutic care. I also authorize and request your company to pay directly to Wholistic Physical Therapy the amount due me in my pending claim for Medical or Physical Therapeutic treatment or service by reason of such treatment of service.

C. FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges. Also, I understand that it is my responsibility to pay all payments, copayments and coinsurance at the time of the visit.

D. APPOINTMENT POLICY

I understand that I will be charged a fee **for appointments not canceled within 24 hours**. This includes canceled appointments, rescheduled appointments, and missed appointments ("no-shows"). Appointments may be canceled via telephone. **The fee is up to the full rate of the visit** but is subject to change at the discretion of Wholistic Physical Therapy. **Self-Pay patients who do not cancel within 24 hours or "no show" to an appointment will be charged the full rate of the session that day $175.00.**

Please initial here _____

E. REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. If an authorization or referral is not obtained by the time of the visit, the visit will be rescheduled and considered a same-day cancellation, resulting in a fee. (SEE ABOVE)

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR IT'S REPRESENTATIVE.

Signature: _____ Date: _____

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CREDIT CARD AUTHORIZATION

The purpose of this Financial Policies form is to be fully transparent and allow us to serve you in the best way possible. When you schedule an appointment at WPT, the time is reserved for you and only you. Since we are reserving this spot just for you, please be conscious of your time and the therapists time. It is always a good idea to arrive 5-10' early, and allow the same time after.

Important Details: - Cancellations made with less than 24-hour notice will result in a full charge - No show patients will result in a full charge If any changes occur, letting us know on time allows other clients to have the blissful opportunity for healing.

I _____ hereby authorize Wholistic Physical Therapy to charge my credit card account in the full amount of my scheduled session in the event that I do not call to cancel or reschedule my appointment at least 24 hours in advance of my scheduled appointment or with prior notice.

I also consent to this information being kept securely on file behind a PCI Compliant firewall for additional charges or statement balances outlined below.

Please note: • Payment is expected when services are rendered. • The patient is responsible for all charges for services provided by WPT that are otherwise not covered by your insurance company. This may include deductible payment, co-pays, co-insurance, or any other monies not covered by your insurance.

• If insurance was pre-verified by WPT we will submit your insurance claim.

• Verification is not a guarantee of payment by the insurance company. The patient is responsible for knowing benefit knowledge of his or her own insurance and is responsible for all payment of services.

I have read this Wholistic Therapy Financial Policy and understand that the client/patient is ultimately responsible for all charges for services provided/rendered by WPT

_____ _____

Patient Signature Date

CREDIT CARD INFORMATION

Credit Card # _____

Expiration Date _____ 3-digit CVV/AVS code _____

BILLING ADDRESS (if different to the one you have already provided us)

Street _____

City _____ State_____ Zip Code_____

As the credit card holder, I hereby authorize transactions from this provider.

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Wholistic Physical Therapy, P.C.

TEN TIPS TO ENHANCE YOUR TREATMENT SESSIONS (yours to keep)

- **LISTEN TO YOUR BODY** before, during, and after treatment. Identify any areas of redness, tenderness, tightness, or tingling on the body.
- **REFRAME YOUR NOTION OF "PAIN"**
  Allow yourself to soften your experience of pain. Instead of identifying with the pain, become aware of the "sensations" occurring in your body. Concentrate on the areas where sensations are present.
- **BREATHE INTO SENSATIONS**
  As you breathe, imagine that you are blowing air out of your body through the area that is producing the most sensation. This type of breathing puts you in touch with your body and thereby enhances your body awareness.
- **UNWIND** – Allow your body to move.
  As movement occurs, fascial restrictions are being released.
- **EXPRESS EMOTIONS** experienced during or after your treatment session with your therapist. The fascial system holds emotions in the body in the form of pain that may be preventing you from getting better. Often, with the release of emotions, the pain will decrease and you will feel better.
- **USE IMAGES OR MEMORIES**
  Share them with your therapist to help locate the source of your pain.
- **COMMUNICATE** with your therapist! Tell us what you feel, what you eat, anything that might be relevant to help you more. Even things that may seem non-related, silly or embarrassing. The therapist cannot help you if you do not talk honestly with them.
- **STAY POSITIVE**
  Remember to reinforce your intention to enjoy a pain-free, active lifestyle by giving yourself messages such as "I am getting better everyday."
- **REMAIN FOCUSED**
  You may experience setbacks. This is sometimes part of the healing process. Keep focusing on your goals and the progress you have already made to help you through each treatment session. You are on your way!
- **SET GOALS**
  Visualize the attainment of your goal. Establish a time-frame for this to occur. If goals are not completed on time, it is O.K. Stay focused and know that the healing will occur.

Remember that "pain is simply a signal or message your body is trying to give you." By listening to your pain and relaying these messages to your therapist, the road to recovery will seem more within your reach. By being more present and aware, in treatment and life, you'll get more out of it.

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Please will You Do Us a Favor?

Dear Valued Patient,

Here at Wholistic Physical Therapy, our mission is to assist as many people as we can on the road to healing and recovery and obtaining a pain free lifestyle- *but we need your help!* It's very simple! If you're happy with us, tell the world! Word of mouth referrals are how we build our business and mean the world to us.

So, we would greatly appreciate a review, *in your own words*, on Yelp.com Just search for Wholistic Physical Therapy on www.yelp.com (in either location) to find us. You may include topics such as how you felt at the beginning when treatment started, how you feel now, and what progress you have made. By writing a review, you will potentially help many others benefit from Myofascial Release.

Here is a direct link to our Yelp page: https://m.yelp.com/biz/wholistic-physical-therapy-brewster

Or Google reviews: if you already have a Google account login:
https://business.google.com/reviews/l/08912289483297825236

We truly appreciate your time, effort, and contribution to the growth and success of Wholistic Physical Therapy.

Warm Regards,
Scott van Niekerk


Find us on Facebook at https://www.facebook.com/WholisticPT

Follow our Twitter account at https://twitter.com/WholisticPT

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Wholistic Physical Therapy, P.C.

Ask us about Juice Plus Whole Food Concentrates!

Front side Rack

Back side Rack

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