The Pilates Wellness Center

Leaner I Longer I Firmer I Stronger

Consent Forms

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Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated at The Pilates Wellness Center which may include Chiropractic, Acupuncture, Pilates, Yoga, Barre, Massage Therapy, Nutritional & Lifestyle Consultation and any other sessions or services I may receive.

I further understand that such sessions may be performed by The Pilates Wellness Center and/or other licensed professionals who may provide services for me now or in the future. I understand I have the opportunity to discuss with the licensed professionals and/or with office personnel the nature and purpose of these services. I understand that results may vary and are not guaranteed.

I understand and I am informed that, as in the practice of medicine and all healthcare, the practice of Chiropractic carries some risks including but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the Chiropractic Physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Chiropractic Physician to exercise judgement during the course of care by which the Chiropractic Physician feels are in my best interest at the time based upon the facts then known. If deemed medically necessary, I consent to diagnostic x-rays of me (or of the patient named below, for whom I am legally responsible for) by an independent imaging center.

I understand and I am informed that, as in the practice of medicine and all healthcare, the practice of Acupuncture carries some risks including but not limited to: bruising, sore muscles and aches and possible aggravation of symptoms existing prior to treatment . I do not expect the Acupuncture Physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Acupuncture Physician to exercise judgement during the course of care by which the Acupuncture Physician feels are in my best interest at the time based upon the facts then known.

I understand that any suggested nutritional advise or dietary advise is not intended as any primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patients' diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body. Medical food, dietary/ herbal supplementation and essential oils may be recommended to me. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to use of such substances. Should I experience any problems, which I associate with these substances, I should suspend taking them and call The Pilates Wellness Center as soon as possible.

I hereby assume all risk of loss, damage or injury associated with or incurred during my use of any treatment sessions or participation in any programs including the use of fitness, yoga, barre or Pilates equipment. On behalf of myself, my heirs, beneficiaries, administrators and personal representatives, I waive all claims for injuries or damages arising out of my use of any sessions or participation in any programs including the use of fitness and Pilates equipment, and hereby release the The Pilates Wellness Center, as well as its officers, directors, assigns, members, agents, independent contractors and employees, from all such claims arising out of my use of any treatment sessions or participation in any programs.

I confirm that my physical condition allows me to use the Pilates equipment and participate in The Pilates Wellness Center sessions and programs and that, if I have any question about my physical condition in this regard, I will seek a physician's advise.

I have read and understood the foregoing, and voluntarily sign this Consent to Treatment Form.

Patient Name: _____ Date: _____

Patient Signature: _____

Authorized Person's Signature: _____
I understand if the participant is under 18 years of age, a parental or guardian signature is required.

Patient Health Information

The Pilates Wellness Center is a non-covered entity which means
your personal health information is never going to be stored or transmitted electronically.

We have adopted the following policies:

1. Patient information is kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and laboratories as is necessary for your care. Patient files may be stored in open file areas and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, patient health information, and other documents and information.

2. It is the policy of this office to educate and communicate with our patients via telephone, text, e-mail /internet, or US mail. You agree with all forms of education and communication. If you have a preferred method, please inform us.

3. This office utilizes a number of vendors in the conduct of business. These vendors may have access to patient health information but must agree to abide by confidentiality rules.

4. You understand and agree to inspections of the office and review of documents which may include patient health information by government agencies in the normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services by 3rd party services. As well, your confidential information will never to sold.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the office.

9. You have the right to request restrictions in the use of your patient health information and to request change in certain policies used within the office concerning your patient health information. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the Patient Health Information and Consent Form and any subsequent changes in office policy. I understand that this consent shall remain in force form this time forward.

Important Information & Policy

APPOINTMENTS

I am aware, understand and agree to the following: **Please initial each policy.**

1) _____I understand that all sessions and packages are pre-paid and a credit card is required to reserve an appointment time. These appointment times are held specifically for me.

2) _____I understand I will be charged the full amount of my session if I choose to miss, no show or give less than a 24 hours cancellation notice. I understand there are no refunds, no make up sessions or exceptions of any kind. All services are non-refundable and non-transferrable. If I no-show 2 consecutive times without contacting the PWC my sessions will automatically be put on hold until I resume communication.

3) _____I understand it is my ultimate responsibility to keep my sessions or to reschedule. The PWC does not confirm any sessions prior to scheduled time.

4) _____I understand all services and packages purchased have an expiration from day of purchase and no exceptions are given regardless of the circumstance.

5) _____I understand in order for PWC to run efficiently, all sessions start and end promptly on time. Should I arrive late for Pilates, Barre, Yoga. Massage or Nutritional Consultation, I understand my session will begin when I arrive and end on time. Patients more than 15 minutes late are considered cancelled.

6) _____I understand in order for PWC to run efficiently, all sessions start and end promptly on time. Should I arrive late for Chiropractic or Acupuncture, I understand the practitioner will try to accommodate my lateness up to 15 minutes after my scheduled treatment time, but I may be asked to wait, or my treatment may be cut short in order to treat on-time patients. Patients more than 15 minutes late are considered cancelled

7) _____I understand there may be other clients receiving sessions at the same time I am. I agree to turn my cell phone off, keep my voice to a minimum, and be respectful to the other clients. I agree to not wear perfume, skin lotions, hairspray or other fragrances as other clients may have chemical sensitivities.

8) _____I understand it is necessary for me to wear long stretchy ankle length pants, clean socks and a Tshirt that covers my full torso (including back and shoulders) for Chiropractic, Pilates, Yoga, and Barre sessions. I understand if I do not wear the appropriate attire to my session it will not be conducted and I will be charged the full amount of my session.

9) _____I understand it is necessary for me to wear loose pants and a loose shelved top for Acupuncture sessions. I understand the practitioner needs to have access from my knees to feet and my elbows to hands. As well, I understand, at times, it may be necessary to have access to my abdomen and/or back. I understand if I do not wear the appropriate attire to my acupuncture session, I hinder the practitioner's ability to perform acupuncture and my treatment will be limited.

10) _____I understand that my sessions will be terminated without refund or notice if I do not adhere to the PWC policies.

NUTRITIONAL SUPPLEMENTATION AND PRODUCTS

I am aware, understand and agree to the following: **Please initial each policy.**

1) _____I understand that nutritional supplementation and products may be recommend to me to support my body's physiological functions and are not intended to treat or cure a disease or symptoms.

2) _____I understand, if I choose to purchase any products, full payment is required at time of purchase and/or prior to products being mailed. I understand there are no refunds, exchanges or credits given on any products ordered.

LAB TESTS & TEST KITS

I am aware, understand and agree to the following: **Please initial each policy.**

1) _____I understand that lab tests, saliva tests, stool analysis and/or diagnostic tests may be necessary and should I agree to order these tests, I understand I will be charged the day the test is ordered as all tests are prepaid.

2) _____I understand once the test results arrive it is necessary to meet with my practitioner to discuss the results and recommendations for care.

3) _____I understand if lab kits are given or mailed to me, I will be charged for them the day that day.

BILLING / INSURANCE

I am aware, understand and agree to the following: **Please initial each policy**

1) _____I understand that payment for my appointments, phone consultations, lab tests and products is expected at time of service. We accept cash, check or credit cards. All credit card payments will be processed the same day of appointment or phone consultation.

2) _____I understand The Pilates Wellness Center does not participate with any insurance carrier. We do not submit medical claims on your behalf and we cannot assist you with claim resolution. All services are strictly on a self-pay basis. The PWC does no 3rd party or insurance billing, reporting, coding, processing, or annual expense reporting of any kind whatsoever (this includes Doctor reports, records to insurance companies, insurance report forms, etc.)

3) _____I understand the services The Pilates Wellness Center provides are not covered by Medicare. Medicare Chiropractic coverage extends only to treatment by means of manual manipulation of the spine to correct an acute subluxation. Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

_____ *Advanced Beneficiary Notice of NON-Coverage (ABN)*. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. Signing below means that you have received and understand this notice.

_____If you are a Medicare Part B beneficiary and wish to become a patient of The Pilates Wellness Center, you are required to accept full financial responsibility for all wellness services and maintenance therapy rendered by The Pilates Wellness Center, which are due in full at the time of service. If you are a Medicare Part B beneficiary and at any time develop an acute spinal condition requiring manual spinal manipulation, The Pilates Wellness Center will provide several references of local providers who may assist you until the acute spinal condition resolves at which time you may resume your wellness services and maintenance therapy at The Pilates Wellness Center.

I have read, understand and agree to adhere to the above policies:

Print Name: _____ Date: _____

Signature: _____