Integrative Rehab and Wellness, Inc.
Medical Therapeutic Yoga

Name_____ Today's Date_____
Address_____City_____
State_____ Zip Code_____ DOB_____
Occupation_____ Home Phone _____
Work_____Cell _____
Email_____

Emergency Information
Name_____ Relationship_____
Address_____ City_____ State___
Zip Code_____ Home Phone_____ Work _____
Cell Phone_____

Client Questionnaire
(This information is kept confidential)

How did you hear about us?
_____
History of any current medical condition
_____
Are you currently receiving any therapeutic intervention (physical therapy, massage therapy, chiropractic care, etc) for any medical conditions? If yes, please explain._____
_____
Do you have any previous yoga experience? If yes, please explain._____
_____
What are your goals for medical therapeutic yoga? (reduce pain, increase mobility, decrease stress, etc.)_____
_____
Any special tests that have been performed, the body part tested, and the results: (ie: X-ray, MRI,CT Scan)_____
_____

Please list all previous injuries, accidents, and any other pertinent medical information
_____
_____
_____
_____

Integrative Rehab and Wellness, Inc.

OFFICE POLICIES & PROCEDURES

Welcome and thank you for choosing Integrative Rehab and Wellness, Inc. for your healthcare needs. All medical therapeutic yoga classes are by appointment only. Please make every effort to arrive on time, however if you realize you will be late please contact us as soon as possible.

CANCELLATION/MISSED CLASS POLICY

All medical therapeutic yoga class series consist of four, one hour sessions. If you are aware that a class will be missed prior to beginning the series, your fee may be pro-rated. Once the series begins, there will be no refunds issued for any classes that are missed.

PAYMENT/BILLING POLICIES

Integrative Rehab and Wellness, Inc. is a fee-for-service clinic. This means that payment is due at the time services are rendered and we will NOT bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may choose submit to your insurance company. If further reports or documentation are requested, these will be provided. We accept cash, personal checks, and credit cards. Medicare will NOT pay for services rendered at Integrative Rehab and Wellness, Inc. as we are *NOT* a Participating Provider with Medicare or any other insurance company, and we only agree to work with Medicare clients for fitness, prevention, and wellness goals (which are not covered services under Medicare). You will not be able to submit for reimbursement as our services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually possess. Signing below means that you have received and understand this notice. You may receive a copy upon request at any time. Given you will be paying at the time of services, if your insurance company reimburses our clinic, these monies will be returned to them and a new check must be cut to you personally. Please clarify prior to your first treatment if you have any questions regarding charges or fees.

PRIVACY POLICY

I understand that Integrative Rehab and Wellness, Inc. will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

CONSENT TO TREATMENT

I agree to the rules and regulations set forth by the physical therapist for safe participation in Medical Therapeutic Yoga. I have read and fully understand the above statements. I understand the nature of the treatments at Integrative Rehab and Wellness, Inc. I authorize Jessica Hartmann, PT, to use treatment techniques as deemed necessary for my safe and effective recovery.

I have read and completely understand the above written statements.

X_____Date_____

Signature of client/legal guardian

I also understand that Medicare will not reimburse for services rendered by Integrative Rehab and Wellness, Inc.

X_____Date_____

Signature of client/legal guardian