Forms Package:
CRANIOSACRAL CLIENTS

LAFAYETTE PHYSICAL THERAPY, INC.
3468 Mt. Diablo Blvd. Suite B110, Lafayette CA 94549

Welcome to Lafayette Physical Therapy!

We wanted to take the time to thank you for choosing us as your wellness partner. Our goal is to provide individualized care to meet your needs no matter what you are seeking care for or what services you are using. Please do not hesitate to speak with our Front Desk if you have any questions or concerns at (925) 284 – 6150.

Please review and complete the attached paperwork and bring it with you to your first visit. The paperwork attached is for **CRANIOSACRAL CLIENTS**. If you are seeking different services such as Wellness/Fitness Training, Massage, or Physical Therapy, please contact our front desk for new forms or download the correct forms from our website.

Please arrive 15-20 min early for your first appointment in order to check in and complete paperwork. If you bring in completed paperwork please arrive 5 min early.

What to Bring

- Completed Paperwork
- Method of payment or gift certificate (if applicable). Payment is due at the time of service. We encourage you to purchase packages in order to receive a discount on select services and so you don't have to make a payment on each visit.
- For minors – please have a Parent or Guardian complete the paperwork and attend the first visit for clients under the age of 18 years.

What to Wear

Please wear comfortable clothing that will allow the practitioner to gently touch and sense your body over your clothes.

Scheduling & Attendance

We encourage you to book out several weeks in advance, especially if you have specific days or times you prefer. Please review the "Late cancellations & No Show Policy", as well as our other important policies and procedures for specific information on our agreements with our clients. To schedule an appointment please stop by our front desk or call them at (925) 284-6150 for assistance.

Throughout Your Care

Communication throughout your care is very important. If you have questions about your services, progress, goals, or any other part of your care at Lafayette PT please discuss them with your practitioner or a member of our staff. If you have questions about your account, billing statements, or any other items please ask to speak to our administrative team right away.

Thank you and we look forward to working with you towards your wellness & fitness goals!

Rev. 3-24-17

Lafayette Physical Therapy, Inc.

Wellness & Massage Services

Client Information

Last Names	First Name	MI	Sex M F
Home Phone	Cell/Alternate	DOB	AGE
Address (No P.O. boxes please)	City	State	Zip
Emergency Contact Person	Relation	Phone	

How did you hear about us?

☐ Friend/Family ☐ Doctor ☐ I am returning ☐ Website ☐ Internet Search ☐ Other: _____

Automated Appt. Reminders: **Please select one phone number &/or e-mail to receive appt. reminder notifications on**

☐ Home ☐ Cell/Alternate ☐ Work ☐ Email: _____ ☐ No reminder

Would you like to receive our e-mail newsletter? Yes – e-mail: _____ ☐ No

Client Policies

1. **PAYMENT:** Clients who participate in wellness and massage services are required to pay at the time of service. For your convenience, we have an easy payment option that keeps your credit card information securely on file and a set amount will be debited each visit/week/month. Should you choose this option, please request the form from our front desk, complete, and return to our office.

2. **PACKAGE DISCOUNTS:** If you are receiving a discount through the purchase of a package, all payments are due on the first visit of that package; otherwise the standard rate applies. Package rate discounts are contingent upon attending the allotted sessions purchased. If a refund is requested for unused sessions, the amount of your sessions will be readjusted to reflect the standard rate; in some cases a refund will not be due after the standard rate is applied. Please be aware that a larger discount may be given for longer session packages and therefore the rates cannot be directly applied to shorter sessions.

3. **ACCOUNT RESPONSIBILITY:** I understand that I am responsible for the full payment for these services. Lafayette Physical Therapy will not bill your insurance.
   ***Medicare Eligible Participants:** Wellness services are optional services intended to increase your wellbeing, and **will not be billed to or paid by Medicare.**

4. **OVERDUE ACCOUNTS & FEES:** Payments are due at the time of your appointment. In the event that you have a balance on your account, please submit payment upon receipt of a statement or being notified by the front desk. Statements may incur a $15 printing/processing fee. Accounts 60 days or more overdue may be assessed a late fee of $25 and assigned to a collections agency (Transworld Collection Agency). A $25.00 fee will apply to any returned checks.

5. **NO SHOW OR CANCELLATION POLICY:** Please understand the importance of your appointment. Lafayette Physical Therapy Inc. **charges the cost* of the class or session for no show or same day cancellations** (cancellations with less than a 24 hour notice.) If you purchased a package of sessions and have a credit on your account, your no show/cancellation fee will be deducted from that amount and will count as one of your purchased visits.
   *Massage cancellations are charged at $50 towards the session.

_____ Client Initial

Please continue on reverse

Office use only

FD Initials: ____

6. **TIMELINESS OF APPOINTMENTS:** Please be on time for your sessions. The instructor/equipment is scheduled for you specifically for the duration of your appointment time. If you are running late please call our office as soon as possible so we can attempt to accommodate you at a later time, arriving late may result in decreased time available on the equipment. If you are late by 10 minutes or more you may be required to reschedule or wait for the next available appointment. If you are unable to be seen due to tardiness you may be charged the no show fee above.

7. **PRIVACY ACKNOWLEDGEMENT:** I understand that I have the right to review LPT's notice of privacy practices prior to signing this document. The full notice is posted in the waiting room and I have read and understand the notice. The notice of privacy practices describes the types of uses and disclosures of my protected health information and is summarized below. I further acknowledge that I have the right to request a copy of the notice.

   CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: I also understand that when necessary, LPT or anyone affiliated with our organization may contact me at any phone number provided. Your verbal communication and clinical records are strictly confidential. The following are the ways that we use your information and communications: (1) Services: information shared with our staff to provide quality fitness session and billing, (2) Payment: information on your diagnosis, dates, treatment, etc. shared with your insurance company to process your claims (Physical Therapy Services only), (3) Internal Administrative Activities: including quality control audits, software updates, etc, (4) Appointment Reminders: may be provided to a phone number or e-mail of your choosing. You may discontinue reminder calls or emails at any time by contacting our office in writing. (5) When required by Law, (6) To inform you of treatment alternatives or update you on relevant products or services offered, (7) Emergencies, (8) When you sign a release to have information shared.

8. **RELEASE OF LIABILITY AND INFORMED CONSENT:** I have read and understand the enclosed Release of Liability Waiver included in the intake paperwork. I understand that it is my responsibility to consult my medical doctor to ensure I am cleared to participate in any wellness and/or massage program (Any fitness classes, individual or group sessions, AlterG use, Massage, or any other class, program, or activity under the wellness services at Lafayette Physical Therapy). I understand that some services such as the AlterG are self directed exercise and I am responsible for my own health and fitness. Lafayette Physical Therapy, Inc. assumes no liability for my health while using the equipment under the self directed programs.

9. **PARTICIPATION AND COMMUNICATION AGREEMENT:** You are responsible for your safety. If you need any modifications to the service or know of certain positions/activities that your body does not tolerate, it is your responsibility to bring this to your instructor's attention and it is your responsibility to avoid these activities. If you experience any pain during your participation it is your responsibility to bring it to your instructor's attention and to cease the activity causing the pain.

10. **PERMISSION FOR MINOR TO PARTICIPATE**: If the participant is a minor, I consent to this minor participating in the wellness and/or massage programs at Lafayette Physical Therapy, Inc. I am responsible for this individual and their safety at all times. I understand that at times it may be necessary to schedule appointments around school hours and that it is my responsibility to ensure he/she is on time for his/her treatment.

_____	_____	_____
Minor's Name	Signature	Date
_____	_____	_____
Parent or Legal Guardian Name	Signature	Date

I attest that all information I have provided to Lafayette Physical Therapy regarding my condition and personal information is true and correct. I have read and understand the terms for Private Pay Clients. A photocopy of this agreement shall be as valid as the original.

Thank you for choosing Lafayette Physical Therapy for your Wellness needs

_____	_____
Client/Guardian Signature	Date

Rev. 09-15-14

LAFAYETTE PHYSICAL THERAPY, INC.

Massage & Wellness Programs - Release of Liability

We advise you to consult with your medical doctor prior to commencing a new exercise, stretching, strengthening, massage, or any other wellness program. All wellness, massage, and other non-Physical Therapy services shall be referred to as "wellness program" in this release. In consideration of being allowed to participate in any way in the Lafayette Physical Therapy wellness services program, related events and activities the undersigned acknowledges, appreciates, and agrees that:

1. My Responsibility: I understand that is my responsibility to notify my instructor/practitioner or a Lafayette PT staff member if I have any questions/concerns, experience any unusual pain fatigue or other issues while participating in any wellness programs at Lafayette Physical Therapy, Inc. I understand that the risk of injury from activities involved in this wellness 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. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases or others, and I assume full responsibility for my participation. 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 official immediately; and
2. Waiver of Liability: I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless Lafayette Physical Therapy, their officers, officials, agents, contractors, employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event, 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 including releasing Lafayette Physical Therapy, Inc. from liability to the fullest extent permitted by law. This agreement applies to personal injury (including death) from accidents or illness arising from participation at Lafayette Physical Therapy, Inc, including, but not limited to, organized activities, classes, observation or individual use of equipment or private facilities, providing CPR, AED and any other emergency medical assistance, and parking area; and (2) any and all claims arising from the damage to, loss of, or theft of property; and
3. Indemnification: I agree to HOLD HARMLESS AND INDEMNIFY Lafayette Physical Therapy, Inc. from all claims resulting from my negligence and to reimburse them for any expenses incurred as a result of my involvement in Lafayette Physical Therapy, Inc. programs. I further agree to pay all costs and attorneys' fees incurred by Lafayette Physical Therapy, Inc. in investigating, and defending a claim or suit if my claim is withdrawn, or to the extent a court or arbitration determines that Lafayette Physical Therapy, Inc. is not responsible for the injury or loss; and
4. Severability and Venue: The undersigned further expressly agrees that the foregoing waiver and assumption of risk agreement is intended to be as broad and inclusive as is permitted by the law of the state of California and that if any portion thereof is held invalid, it is agreed that the remaining provisions shall continue in full force and effect. Likewise, I agree that if legal action is brought, it must be brought in Contra Costa County, CA; and
5. Acknowledgement of Understanding: I have read this waiver of liability and fully understand its terms. I understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily, and intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law in the State of California.

_____	_____	_____
Participant Name	Signature	Date
_____	_____	_____
Parent/Guardian Name (If participant is under 18 at the time of registration)	Signature	Date

CranioSacral Therapy

Confidential Health History Information

Our goal is to make your appointment as pleasant and comfortable as possible.
If you have any questions at any time regarding your visit, please let your practitioner know.

Client Name: _____ Age: _____

Have you ever received CranioSacral Therapy before? Y ____ N ____
If yes, what was your experience with this method? _____

_____

How did you hear about CranioSacral Therapy? _____ Previous Session Dates?: _____

Are you receiving treatment now by a medical practitioner for any condition? Y ____ N ____
If yes, please describe: _____

Health History Questionnaire (Please answer Y for Yes or N for No, and fill in the blank for the following):

1. Have you ever had a stroke, cerebral hemorrhage, an aneurism or cerebrospinal fluid leakage? Y ____ N ____
2. Have you ever sustained injuries to the head and neck, such as a concussion or whiplash? Y ____ N ____
3. Have you had any bone fractures in the past? Y ____ N ____
4. Are you experiencing osteopenia or osteoporosis? Y ____ N ____
5. Have you ever had surgery? If yes, please describe briefly: _____ Y ____ N ____
   _____
6. Have you ever been diagnosed with an autoimmune disease, such as rheumatoid arthritis? Y ____ N ____
7. Do you have an established coping pattern when dealing with stress? Y ____ N ____
8. Do you have any pain, discomfort, or concerns you would like to address today? If yes, please describe:
   _____
   _____
   _____

9. Is there anything else you think I should know about you to create a safe and comfortable environment?
   _____
   _____
   _____

10. What results would you like to create from your session today? _____
    _____
    _____

I understand that the CranioSacral Treatment sessions I receive are provided for the purpose of relaxation and relief of connective tissue tension. If I experience any discomfort or pain during this session, I will immediately inform my practitioner. I understand that CranioSacral work is not a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any physical or mental ailment that I am aware of. Because CranioSacral work should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. If I have any concerns about CranioSacral Treatment services based upon my medical condition, I understand that I should contact my health care provider prior to receiving CranioSacral Treatment to discuss the impact of the work on my condition. I agree to keep my CranioSacral Practitioner updated as to any changes in my medical profile at the beginning of each session. I agree to release my CranioSacral Practitioner and the company/location at which the service is performed at from liability arising indirectly or directly from a CranioSacral session.

Client Signature: _____ Date: _____