New Patient Registration

Name: _________________________ Date of birth: ___/___/___ Today's Date: ___________

Address: ____

City: _________________________________ State: _________ Zip Code: __________________

Phone (home):______________________________ (cell): ______________________________

Email address:____

May I leave messages at the numbers above? ___ Yes ___ No

Who can we thank for sending you to Sakash Health and Wellness?

____

Referring Physician: ____

Referring physician phone:____

Referring physician fax: ____

Name of person I should contact in case of emergency: ________________________________

Phone number: ____

Relationship to you: ____

SAKASH
HEALTH AND WELLNESS

Medical History Form

Name: ____ Date: __________________

Height: ______ Weight: ______lbs General Health: Excellent__ Good__ Fair__ Poor__

Smoking: Yes / No If yes, how many cigarettes per day___ per week___ occasional___
Alcohol: Yes / No If yes, how many drinks per day___ per week___ occasional___

Medical conditions/diagnoses: (Mark all that apply)

High Blood Pressure
High Cholesterol
Blood Disorder
Diabetes
Night Pain
Asthma
Dizziness
Arthritis
Osteopenia
Depression

Heart Problems
Autoimmune Disorder
Vascular Problems
Liver Disease
Cancer
Shortness of Breath
Epilepsy/Seizures
Fractures
Osteoporosis
Anxiety

Infectious Disease
Multiple Sclerosis
Stroke
Kidney Disease
Parkinson's Disease
COPD
Thyroid Problems
Scoliosis
Chronic Pain
Incontinence

Other(s)____

Medications (Including supplements):____
____
____
____

Past Injuries/Surgeries with dates: ____
____
____
____

Women: Is there any chance you could be pregnant? Yes___ No___

Have you had any recent medical tests? X-ray_____ MRI_____ CT scan_____ Bone density____

EMG____ Blood test_______ Urinalysis___ Other Tests/Results: ______________________________

Do you use any assistive devices? None___ Cane___ Walker___ Hearing aids___ Glasses___
Other ________________________

Please describe your current condition and symptoms that have lead you to seek out treatment:
____
____

When did your symptoms start? _____/_____/_____

How did your symptoms develop? Injury (explain): ____
____

Have you received other treatment for your current condition? Yes /No
If yes, what type of treatment? ____

Was it helpful? Yes / No

What has your average pain level been over the last couple of days (circle):

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

Where is your pain located?_______________________ How would you describe the pain? _________
What makes your symptoms worse? ____
What eases your symptoms? ____

What are your goals/expectations for physical therapy? _______________________________________
____
____
____
____

Notice of Privacy Practices Acknowledgement

The Sakash Health and Wellness HIPAA Notice of Privacy Practices is available on our website under "Forms". If you are unable to access this, a written copy can be provided to you upon request.

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices.

____ ____________________________

Patient's or Guardian's Signature Date

Policies and Procedures

Name: ___________________________________ DOB: ______________________

The following policies and procedures are designed to provide a dependable, safe, and productive experience for our clients. Please read thoroughly. If you have any questions or concerns, please let us know. Your signature at the bottom of the page verifies that you have read and will abide by the Sakash Health and Wellness program policies and procedures. Thank you.

Patient Consent

I hereby consent to the administration of appropriate physical therapy evaluation and therapeutic procedures as requested by the physician prescribing care and/or via the laws of direct access. In doing this, I understand that the therapist will monitor my progress and adjust treatment frequency and duration according to medical necessity.

________ Patient/Guardian Initials

Treatment Sessions

Initial evaluations and follow up treatment sessions are 1 hour in length. For your evaluation and each follow up visit, please wear clothes that are appropriate for exercise and that allow the affected area to be exposed. (such as shorts, yoga pants or sweatpants and t-shirt or tank top).

Newsletter and Contact

If you supplied an email address, you can receive our email newsletter. This will include updates, news, classes, deals, presentations and the like. If you wish to receive these, please initial here

_______Patient/Guardian Initials

Sakash Health and wellness requires 24 hours advanced notice via email, the Mindbody scheduling system, or voicemail for all session (class and appointment) changes. When you schedule a session, that time and space is reserved solely for you. Your teacher/therapist will spend time planning and designing a session for that day to help you meet your goals. Missed and frequently rescheduled classes and appointments will interfere with your progress and keep you from meeting your goals. In addition, when a session is missed without giving advance notice, or a change is requested at the last minute, we lose the opportunity to offer that time to someone else who is on our waiting list.

Clients are responsible for all sessions they have scheduled. Clients who choose not to attend, or those who call to move their sessions at the last minute, will be charged a fee equal to the amount of their missed appointment. These fees for missed appointments will be expected on the day of the missed session and will be processed using the card on file to hold the reservation.

Tardiness
We suggest that you arrive for your appointment 5 minutes before the scheduled start time and that you are considerate of the next client's time when your session ends. Please know that if we start late your treatment time will be shortened and the regular fee will apply.

Cancellations/Absence on Arrival
I acknowledge that I must provide 24 hours notice if I am unable to keep my appointment. Failure to give 24 hours notice will result in a charge equal to the amount of my missed appointment.

_______ Patient/Guardian Initials

By signing below, I certify that I have read the above policies and procedures, understand them, and will comply with them. I agree that Sakash Health and Wellness retains the right to charge me for scheduled appointments missed by late cancellations, or absence on arrival as described above.

____

Signature of Patient/Guardian Date

____

Print Name of Patient/Guardian

Consent for Methods of Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Sakash Health and Wellness respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. Sakash Health and Wellness will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

__ I do not consent to any voicemail, email or texting communication.

__ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all that you consent to):

- o Email
- o Text
- o Voicemail

__ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to)

- o Email
- o Text
- o Voicemail

E-mail address you are consenting to communicate through: ____________________________

Phone number you are consenting to communicate through:____________________________

Patient/Client Signature:_______________________________ Date_____________________

Authorized Representative/Guardian Signature:________________________ Date__________

Consent and Release for Use and Disclosure of Image, Voice, and/or Written Testimonials

I, ________________________________ consent to the photographing, recording and unlimited use of my likeness (including my name, voice and/or image) for commercial, promotional or other use, in any medium, by Sakash Health and Wellness and its employees, affiliates, subsidiaries, licensees, successors, and assigns. I waive all rights of attribution, inspection, or approval for any use of my likeness. Sakash Health and Wellness and its employees, affiliates, subsidiaries, licensees, successors, and assigns are held expressly harmless for any liability, legal and/or financial, incurred as a result of said use. I waive any right to royalties or other compensation arising from or related to the use of my likeness. All right, title, and interest to any photographs, recordings, and any other materials using my likeness shall be the sole property of Sakash Health and Wellness. I shall have no interest in any such materials nor shall I have any right to use the name or trademarks of Sakash Health and Wellness without its express, written permission

I HEREBY ACKNOWLEDGE THAT SAKASH HEALTH AND WELLNESS OR ANY OF ITS AGENTS OR EMPLOYEES HAVE NOT MADE ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND WITH RESPECT TO ANY MEDICAL OR OTHER ADVICE OR INFORMATION THAT I MAY RECEIVE IN CONNECTION WITH MY APPEARANCE AND THAT I HAVE NOT RELIED ON ANY SUCH REPRESENTATIONS OR WARRANTIES IN AGREEING TO PARTICIPATE IN THE RECORDING OF MY VOICE AND/OR LIKENESS AS DESCRIBED ABOVE OR IN THE EXECUTION OF THIS CONSENT FOR USE AND DISCLOSURE OF IMAGE, VOICE AND/OR WRITTEN TESTIMONIALS (THE “CONSENT”).

I am signing this Consent and Release voluntarily, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization for Use and Disclosure of Protected Health Information for Marketing and Promotional Purposes (the “Authorization”), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

____

Signature of Client/Guardian   Date

____

Print Name of Client/Guardian

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization (WHO). **COVID-19 is very contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Sakash Health and Wellness ("SHW") has put in place preventative measures to reduce the spread of COVID-19; however, the SHW **cannot guarantee** that you will not become infected with COVID-19. Further, attending SHW could increase your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending SHW and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at SHW may result from the actions, omissions, or negligence of myself and others, including, but not limited to, SHW employees and program participants.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my attendance at SHW or participation in SHW programming ("Claims"). On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless SHW, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of SHW, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any SHW program.

____

Signature of Client/Guardian   Date

____

Print Name of Client/Guardian