Boundless *LLC*

Myofascial Release and Physical Therapy New Client Forms

Name: ____ **DOB:** ____________ **Date:** _____________

Address: ____

City: ____ **State:** _________ **Zip:** ___________

Emergency Contact name/number: ____

How did you hear about Boundless? ____

Referred by another care provider* (name if applicable)_____________________________________

* We will fill out a medical release form if you desire to keep your care provider updated on your progress.

Consent for Communication:

Clients frequently request that we communicate with them by phone, voicemail, email or text. *Boundless LLC* 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. *Boundless LLC* 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 ***initial*** below to indicate below what types of correspondence you consent to receive.

______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 ("x" all that you consent to):

- ◯ Email
- ◯ Text
- ◯ 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 ("x" all that you consent to):

- ◯ Email
- ◯ Text
- ◯ Voicemail

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

Phone number you are consenting to communicate through:________________________________

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Consent to Treat: Referenced policies may be accessed at www.boundlesspt.com under the "Prepare" tab, or a written copy provided upon your request. (Please ***initial*** below):

_______I HAVE HAD THE OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES POLICY. I understand that Boundless LLC and owner, Bethany Kempfert, PT will maintain my privacy to the highest standards and may use or disclose my personal health information only for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

_______I HAVE HAD THE OPPORTUNITY TO REVIEW THE PAYMENT AGREEMENT POLICY, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by *Boundless LLC* and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. I understand that *Boundless LLC* may provide both wellness and physical therapy services, often intertwined in the same session. This may result in my insurance considering this a non-covered service.

_______FOR MEDICARE BENEFICIARIES: I understand that *Boundless LLC* and it's provider, Bethany Kempfert, PT, are "non-enrolled" with Medicare, therefore no services provided by Boundless will be reimbursable by Medicare. Mark "x" for applicable statements below:

- ◯ I come to Boundless LLC seeking wellness services, which *is not* covered by Medicare. I understand that if I desire a physical therapy intervention that *is* covered by Medicare, I have the right to search out a Medicare "participating provider".
- ◯ I desire to receive treatment by *Boundless LLC*/Bethany Kempfert, PT regardless of whether it may qualify as a covered service by Medicare. I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting *Boundless LLC* and my therapist from submitting any claims to Medicare pursuant to my rights and privacy under HIPAA.

_______I understand that I have the right to access this service without a referral for treatment of musculoskeletal injuries with the exception of acute fractures or soft tissue avulsions, but agree that if my doctor does refer me, Bethany Kempfert, PT, will have a responsibility to communicate with the referring provider as necessary to ensure continuity of care. I understand that Bethany Kempfert, PT, will not provide a medical diagnosis, and must refer me to an appropriate healthcare provider if necessary services exceed the PT scope of practice.

____
Printed name of Client/Guardian

____ __________________
Client or Guardian's Signature Date

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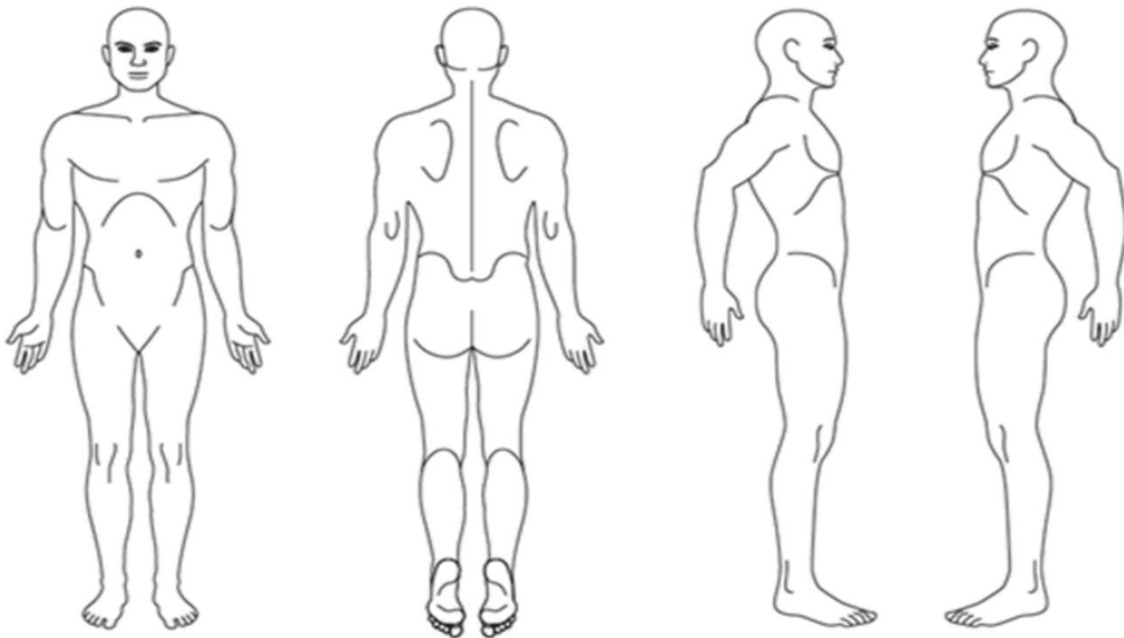
What brings you to *Boundless?* Do you have specific goals for your session(s)? _________________

____

____

Pain Drawing: Please shade areas of current or recent pain or discomfort on the drawings below.



Pain scale: Please circle numbers below that indicate the best and worst intensities of your most problematic pain area in the last 24 hours.

No pain 1 2 3 4 5 6 7 8 9 10 Worst imaginable

What makes your pain worse: ____

____

What makes you pain better: ____

____

Trauma/Injury history: ____

____

____

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Medical History: (please list any current conditions, or past problems that still impact you)

Ears, Nose, and Throat ____

Cardiovascular (Heart, BP, Stroke, etc.) ____

Respiratory (Asthma, Emphysema, etc.) ____

Gastrointestinal (Stomach, Ulcers, etc.) ____

Genital, Kidney, Bladder ____

Muscles, Bones, Joints (Arthritis, etc.) ____

Skin (Acne, Warts, Skin Cancer, etc.) ____

Neurological (Multiple Sclerosis, Headaches, Seizures, etc.) _____________________________

Endocrine (Diabetes, Thyroid, etc.) ____

Blood, Lymph (High Cholesterol, Anemia, etc.) ____

Allergic, Immunologic (Hay Fever, Lupus, etc.) ____

General Health (Fever, Weight Gain/Loss, Unusually Tired, History or current cancer, etc.) __________

____

Social/Emotional (Depression, Anxiety, etc.) ____

History of Accidents, Traumas ____

Pregnancy (how many weeks): ____

Past births (vaginal vs. C-section): ____

Other:____

Surgical history: ____

____

____

Medications: Please list reasons you are taking medications or supplements (such as high blood pressure, joint pain, etc). You do not need to list medication/supplement names, unless you have question/concerns:

____

____

____