Restoring Body Health
Move Better - Feel Better - Live Better

RESTORING BODY HEALTH
FEET UNLIMITED, INC.

PATIENT INFORMATION **Date:** _____

Name: _____ **Social Security #** _____

Address: _____**City**_____**State**_____**Zip**_____

Marital Status: S M W D Gender: M [ ] F [ ] Age: _____ Date of Birth: _____

Home Phone: _____ Please check: [ ] okay to leave message [ ] Please do not leave message

Cell Phone: _____ Please check: [ ] okay to use [ ] Please do not use [ ] Text messages okay
Email: _____ **Please check:** [ ] okay to use [ ] Please do not use
Patients (or Guardians) Employer: _____
Work Phone: _____ **Please check:** [ ] okay to use [ ] Please do not use
Work Address: _____
Emergency Contact: _____ **Phone:** _____
Primary Physician Name: _____ **Phone:** _____
Referred by: _____
Person Responsible for Bill *(if other than the above)* _____

Thank you for choosing Restoring Body Health (RBH), Feet Unlimited, Inc. (FUI) for your health care. We want you to be an informed participant in your health care needs. Our office is dedicated to the principles and ideal of offering to all who come, scientific, professional Pedorthic Foot Care and/or Manual Osteopathic Manipulation, and/or Therapeutic Low Laser Therapy and/or Presso-therapy and/or EndermoTherapy and/or AcuGraph and/or NeurOptimal feedback of the highest standards. Our first obligation is to our patient. High standards of professional service require the Certified Pedorthist, D.O.M.P., A.C.M.T. to devote to each patient ample time to consider his/her individual needs. For this reason, delays may occur in our carefully planned appointment schedule. John is licensed by OK State Board of Pedorthics, American Board of Orthotics, Prosthetics & Pedorthics; National Academy of Osteopathy, Diplomate of International Osteopathy, International Osteopathic Association, and Associated Bodywork & Massage Professionals. Charges vary according to the type and extent of services rendered. I have made the decision to put the health of the patient above the willingness of the insurance carrier to pay. Our practice is cash only and payment for treatment and all supplies is due at the time of each treatment. **We do file VA claims.** **IF YOU ARE UNABLE TO MAKE A SCHEDULED APPOINTMENT, PLEASE INFORM OUR OFFICE AS SOON AS POSSIBLE, SO THAT WE MAY FREE UP YOUR TIME SLOT FOR OTHER PATIENTS.** **We do not accept or file health insurance or accident claims.** We will give you a receipt for charges at the time of payment which can be submitted to your health insurance company for reimbursement. It is ultimately the patient's responsibility to remember his/her scheduled appointments. In the event that you are unable to pay the balance in full, please advise us prior to the time of service. Debit, Visa, Master Card, cash and check are accepted. There will be a $25 service charge on all returned checks. .

AUTHORIZATION

I accept financial responsibility for payment of treatment and/or orthotics and **I will submit my own insurance claims for treatments & orthotics** with information provided to me by RBH/FUI. I understand that all other treatments cannot be filed with my health insurance company. I hereby give my permission to John Chatzigiannidis, C. Ped, D.O.M.P., A.C.M.T. to treat my medical condition. ***"In the event that Restoring Body Health/Feet Unlimited, Inc. must retain a collection agency or law firm to collect past due balances owed to Restoring Body Health/Feet Unlimited, Inc., you agree to pay any and all collection agency fees, court costs, attorney fees or incidental costs associated with collecting." I understand that the Cancellation Policy is that a charge equivalent to the fee of the appointment I miss will be charged if a notice is NOT given to our office within 24 hours of my scheduled appointment. This fee will be collected PRIOR to your next visit.***

I authorize RBH/FUI and any of its employees or other authorized personnel or agents to contact me and or named authorized person(s) to convey personal health information, appointment reminders, (as previously approved), promotions & complimentary treatments and to send thank you letters to my referral source. I assume responsibility to notify RBH/FUI whenever this information changes. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Date: _____ SIGNATURE: _____
(Patient/legal guardian)

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CONFIDENTIALITY AGREEMENT AND INFORMED CONSENT TO TREATMENT AND RELEASE OF MEDICAL INFORMATION

AUTHORIZATION FOR TREATMENT: By virtue of my signature below, I authorize Restoring Body Health (RBH)/ Feet Unlimited, Inc. (FUI), and any of its employees or other authorized personnel or agents, to provide general healthcare service to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize RBH/FUI and any of its employees or other authorized personnel or agents, to release any of my medical records or other personal or medical information to other healthcare providers involved in my care or treatment for purposes of determining benefits for services; for purposes of my obtaining reimbursement from any payer, or for the purpose of developing an appropriate treatment plan or diagnosis.

List name(s) of person(s) authorized to receive information about your care other than insurance companies: _____ _____ I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

Please take a moment to read and initial all of the following statements:

___ I intend this consent form to cover the entire course of treatment with the Certified Pedorthist and/or Manual Osteopathic Practitioner and/or Certified Laser therapist and/or Massage therapist.

___ I understand that every effort will be made to make **orthotics** work for me. I understand the results are not guaranteed. I do not expect Feet Unlimited, Inc. will be able to anticipate and explain all risks and complications.

___ I understand the results of **Manual Osteopathic treatments** are not guaranteed. I do not expect the Manual Osteopathic Practitioner will be able to anticipate and explain all risks and complications.

___ I understand the results of **Presso-Therapy (lymphatic drainage)** are not guaranteed. I do not expect the practitioner will be able to anticipate and explain all risks and complications.

___ I understand the results of **Therapeutic Laser Therapy** are not guaranteed. I do not expect the practitioner will be able to anticipate and explain all risks and complications.

___ I understand the results of **Full light Therapy** are not guaranteed. I do not expect the practitioner will be able to anticipate and explain all risks and complications.

___ I understand the results of **NeurOptimal feedback** is not guaranteed. I do not expect the practitioner will be able to anticipate and explain all risks and complications.

___ I understand the results of **Massage Therapy** are not guaranteed. I do not expect the Practitioner will be able to anticipate and explain all risks and complications.

____ I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Consent for Treatment: If I experience any pain or discomfort during a session, I will immediately inform the practitioner. I further understand that Manual Osteopathic Therapy **and/or** Therapeutic Laser Therapy **and/or** Presso-Therapy **and/or** Custom Orthotics should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. Because Manual Osteopathic Therapy **and/or** Therapeutic Laser Therapy **and/or** Presso-Therapy **and/or** Full Light Therapy **and/or** NeurOptimal feedback should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

DATE: _____ SIGNATURE: _____

I acknowledge that I have been provided access to the Notice of Privacy Practice for Restoring Body Health/ Feet Unlimited, Inc. (Copy available in office)

DATE: _____ __ SIGNATURE: _____

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FEET UNLIMITED, INC, dba RESTORING BODY HEALTH
CANCELLATION/MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. To do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:
In order to be respectful of the medical needs of other patients, please be courteous and call Feet Unlimited, Inc, dba Restoring Body Health office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

No-Show Policy:
A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded to the patient's chart as a "no-show". The first time there is a "no-show" there will be no charge to the patient. Any additional "no-shows" will result in a charge equivalent to the fee of your scheduled visit and billed to the patient's account. This fee will be collected PRIOR to your next visit.

Late Cancellations:
Late cancellations will be considered as a "no-show".

How To Cancel Your Appointment:
To cancel appointments, please call 918-747-8224. I you do not reach the receptionist you may leave a detailed message on the voice mail that is timed and dated. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

Patient Signature: _____ DATE: _____

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Your Health History

What is your chief complaint?_____
When did your pain start? _____
Have you received treatment before? [ ] Yes [ ]No
By Whom? _____ Last treatment date: _____ Did it help? _____
What other treatments or therapies have you tried? _____
How do you feel today? _____
Do you exercise regularly? [ ] Yes [ ] No How often? _____
Your general state of health is: [ ] excellent [ ] good [ ] average [ ] fair [ ] poor
Current Wt: _____ Height _____ Shoe size _____ **Females:** Are you pregnant? [ ] Yes [ ] No

Do you currently use any of the following (indicate how often, how much and for how long)

Alcohol _____ Coffee _____ Soft drinks _____ Tobacco _____

Do you currently or have you ever had any of the following? please check all that apply

_____ Osteoporosis
_____ Joint Replacement
_____ Sciatica
_____ Pins or metal implants
_____ Short leg syndrome
_____ Osteoarthritis
_____ Arthritis
_____ Degenerative Disk Disease
_____ Scoliosis
_____ Polio
_____ Multiple Sclerosis
_____ Numbness or Tingling
_____ Muscle/joint pain or stiffness
_____ Swollen Joints
_____ Dizziness or Fainting

_____ Diabetes
_____ Coronary Heart Disease
_____ Hearing Difficulties
_____ High Blood Pressure
_____ Blood clot
_____ Stroke
_____ Cancer
_____ Chemotherapy or Radiation
_____ Sleeping problems
_____ Shortness of Breath
_____ Bronchitis or Emphysema
_____ Seizures
_____ Severe Headaches
_____ Epilepsy

_____ Asthma
_____ Allergies
_____ Emotional problems
_____ Psychological problems
_____ Bowel problems
_____ Varicose veins
_____ Hernia
_____ Angina
_____ Thyroid trouble
_____ Anemia
_____ Weight loss
_____Energy loss
_____ Goiter
_____ Weakness
_____ Bladder problems

Do you have a Pacemaker or Defibrillator? [ ] Yes [ ] No

Have you ever had an ***INJURY*** or ***SURGERY*** on any of the following?					
	INJURY	**SURGERY**		**INJURY**	**SURGERY**
Head			Elbow		
Facial			Hand/wrist		
Dental			Knee		
Neck			Ankle		
Shoulder			Foot		
Mid-Spine			Concussion		
Lower Back			Heart		
Hip			Pelvis		

Please list any medications you are taking in these medication categories and any vitamins, minerals or supplements:

Anti-inflammatories _____ Pain Medication _____
Muscle Relaxants _____ Other _____

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

Patient/Guardian Signature: _____ Date: _____

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Client Informed Consent

I _____, understand that Neurofeedback is not a medical treatment, device or methodology. It is not used to diagnose medical disorders nor is it used as a medical treatment for disorders and has not been approved for any medical purpose by the FDA, Health Canada or any other governing agency. While Restoring Body Health may or may not be licensed health care practitioners, their use of Neurofeedback is solely as a tool for brain training and optimization and not as a means of diagnosis or as a medical intervention.

I am satisfied with the information I have been provided (verbal, written or otherwise) by my Trainer on the effects I can expect during my Neurofeedback training and my questions have been answered to my satisfaction. I understand that it is not possible to predict what my central nervous system will do with the information it is offered and consequently there can be no guarantee as to the results of my training. I also understand that under normal use, Neurofeedback does not produce side effects. Some users however, may experience some temporary effects from training due to the increase in challenge to the brain that the training represents. This effect typically resolves after a few Sessions.

I agree to cease training if I am less than happy with the results I am getting. I understand Neurofeedback is purely a source of information and does not direct the response of the central nervous system. Consequently I agree to not hold Restoring Body Health or any of its users and Trainers responsible for a less than desired outcome or any outcome that may be considered negative.

_____

YOUR PRINTED NAME TODAY'S DATE

_____

YOUR SIGNATURE

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NEUROPTIMAL.
Advanced Brain Training Systems

MY JOURNAL: CHECKLIST

NAME:

DATE: **PRE/ONGOING/POST:**

Please check off any item that represents how you are feeling using the past week as your guide. Add comments if you wish.

1. Itchy or irritated nose, sneezing
2. Wheezing
3. Catch cold too often
4. Run down
5. Tired
6. Awake too long when you go to bed
7. Waking up during the night
8. Waking up before you want to
9. Difficult to wake up in the morning
10. Bad dreams
11. Difficulty breathing at night
12. Out of bed but not knowing how you got there
13. Skin difficult to manage
14. Hair weaker or less lustrous than you'd like
15. Nails weak, flaking or tearing
16. Blurry vision at times
17. Areas where you can't see anything
18. Spots floating in front of you
19. Difficult to hear
20. Ringing in your ears
21. Ears hurt inside
22. Smells seem different or lost
23. Nose gets blocked
24. Grinding your teeth
25. Things taste different
26. Voice hoarse or sore
27. Can't get enough air
28. Heart too fast or jumpy
29. Pulsing or throbbing in your head
30. Heart skips a beat
31. World spinning around you
32. Might throw up
33. Tummy hurts
34. Gassy, bloated
35. Sensitive digestion
36. Upset stomach
37. Difficulty going to the bathroom
38. Eat when not hungry, or not feeling hungry
39. Trouble eating sweets
40. Urges to eat sweet things
41. Sensitive to heat or cold
42. Slowed down or speeded up
43. Moody at certain times of the month
44. Hot flashes
45. Problems from being of a "certain age"
46. Not interested in your partner
47. Too interested in your partner or other people?
48. Stiff and sore
49. Areas that really hurt when touched
50. Muscles hurt
51. Fatigued
52. Pains in your head
53. Going to pass out
54. Lose consciousness
55. Difficult to remember things
56. Difficult to find your words
57. Difficulty reading
58. Difficult to speak sometimes
59. Shaky
60. Weak
61. Too active
62. Can't balance on one leg
63. Moving your head or saying words you don't intend
64. Difficulty paying attention
65. Easily distracted
66. Make a lot of mistakes
67. Disorganized
68. Difficult to complete tasks
69. Lose your train of thought
70. Difficult to complete studies or work
71. Get into trouble at school or work
72. Mix up numbers or letters sometimes
73. Difficult to know how things fit together
74. Difficulty with some subjects
75. Need to go to the bathroom but hard to start
76. Lose your urine sometimes
77. Difficult to control going to the toilet
78. Stinging sensations when going to the bathroom
79. Drink too much sometimes
80. Smoke cigarettes
81. Concerns about eating
82. Need caffeine to get going
83. Enjoy marijuana
84. Habits that concern you
85. Moody
86. Feeling low or flat
87. Feel sad
88. Concerned about things
89. Feel terrified sometimes
90. Mull about things
91. Thoughts you'd like to stop but can't
92. Need to do things over and over
93. Eat more food than you can comfortably eat
94. Careful to never eat too much
95. Make yourself throw up
96. Difficult to do things you'd like to do
97. Others are against you
98. Get into trouble for your behavior
99. Feeling angry
100. Overwhelmed

Note: Any concerns mentioned are intended as examples only and not meant to suggest that NeurOptimal® treats, mitigates, cures, or diagnoses any listed concern. Instead, identified concerns and medication use are one of many ways to measure shifts in brain functioning and perception.

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Advanced Brain Training Systems

MY JOURNAL: TRACKER

Start your journey here and track as you go.

NAME: DATE:

SESSION #: MY QUALITY OF LIFE ON A SCALE OF 0-10 IS:

ITEM Pick the items that you would most like to see shift	DURATION How long did it last? Do not count when you were sleeping	INTENSITY How strong was it 0-10	FREQUENCY How many times did you feel this way in the past week, or how many days out of 7?
1.			
2.			
3.			
4.			
5.			

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