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)

Restoring Body Health
Move Better - Feel Better - Live Better

YOU'RE HEALTH HISTORY

What is your chief complaint? _____

When did your pain start? _____ Is your pain work related? Yes [ ] No [ ]

Have you received treatment for this before? Yes [ ] No [ ] By whom? _____

Last treatment date _____ Did it help? _____ What other therapies/treatments have you had? _____

How do you feel today? _____

Do you regularly exercise? Yes [ ] No [ ] What type of exercise? _____How often? _____

Your general state of health is: excellent [ ] good [ ] average [ ] fair [ ] poor [ ]
Current weight _____ Height _____ Shoe size _____

Do you have a family history of Diabetes? Yes [ ] No [ ] Do you have Diabetes? Yes [ ] No [ ]

Number of years _____ Do you take insulin? Yes [ ] No [ ] Diet Controlled? Yes [ ] No [ ]

List of all Medical conditions currently under treatment:

_____

_____

_____

Have you had any major back – hip – knee – foot – ankle surgeries? If so, please list:

_____

_____

List all allergies to medications: _____

_____

Allergic to Tape? Yes [ ] No [ ] Allergic to latex rubber? Yes [ ] No [ ]

GENERAL HEALTH INFORMATION

Circle any of the following you have, or have been treated for.

Heart	Asthma	Skin	Neurological Disorder
Circulation	Gout	Phlebitis	Frequent infections
Arthritis	Ulcerations	Healing	Bleeding Disorders
Kidneys	Anemia	Keloids	Stroke/Seizures
Lungs	Bladder	Cancer	High Blood Pressure

I affirm that I have 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.

Patient/Guardian Signature: _____ Date: _____

Restoring Body Health
Move Better - Feel Better - Live Better

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: _____

RESTORING BODY HEALTH
FEET UNLIMITED, INC.

6465 S YALE, STE 608
TULSA, OK 74136

ORTHOTIC INFORMATION

Patient Name: _____ Date: _____

Many of the causes of foot discomfort are due to limited motion, muscle, or ligament strain. Weak foot structure causes foot discomfort when the bones and joints cannot function correctly. Over time pain may develop.

The casting to obtain an impression of the feet, the orthotic, all lab fees, dispensing and one follow-up visit (within 3 months of receiving orthotics) are included in the cost of orthotics. We will require a down payment of $200 at the time of casting + initial visit fee of $95 for new patients. The balance is due at the time of dispensing the orthotics.

These fees are:

Initial Visit …….	**$ 95.00**
Initial Pair ……..... …	**$ 500.00**
Second Pair ……..…	**$ 450.00**
(If you have the cast molds and nothing has changed)	
Refurbishing/recover of orthotics ……	**$ 150.00**
Repair of orthotics……	**$100.00**

Foot exam (Podoscope) $60.00
Biomechanical exam (Podoscope photos, Gait video) … … … … …$ 100.00
Full Biomechanical exam (Podoscope photos, Gait video, Postural photos, Postural Evaluation)… $125

NOTE: Future examinations and further testing, if necessary, are **NOT** included in the cost of orthotics. The orthotic is non-refundable. After the initial follow-up orthotic check, a fee of $50 will be charged for additional orthotic adjustment visits.

Every effort will be made to make the orthotics work for you. The first follow-up visit is very important. At that time, adjustments, if necessary, will be made.

In the past, we have found that many insurance companies do not provide benefit coverage for custom foot orthotics. **We do not file insurance claims.** We will provide you with a form with the information you will need to file with your insurance company and we will provide any additional information the insurance requests.

(Payment Plan arrangements may be made) By signing you are accepting responsibility for the entire cost of the orthotics.

Signature: _____ Date: _____

THE ORTHOTICS ARE NOT RETURNABLE FOR A REFUND OR CREDIT

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: _____