



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 Pressotherapy 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)

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: _____



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. If 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: _____



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

- | | | |
|---|--|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Pins or metal implants | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychological problems |
| <input type="checkbox"/> Short leg syndrome | <input type="checkbox"/> Blood clot | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Degenerative Disk Disease | <input type="checkbox"/> Chemotherapy or Radiation | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Bronchitis or Emphysema | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Seizures | <input type="checkbox"/> Energy loss |
| <input type="checkbox"/> Muscle/joint pain or stiffness | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Dizziness or Fainting | | <input type="checkbox"/> 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		

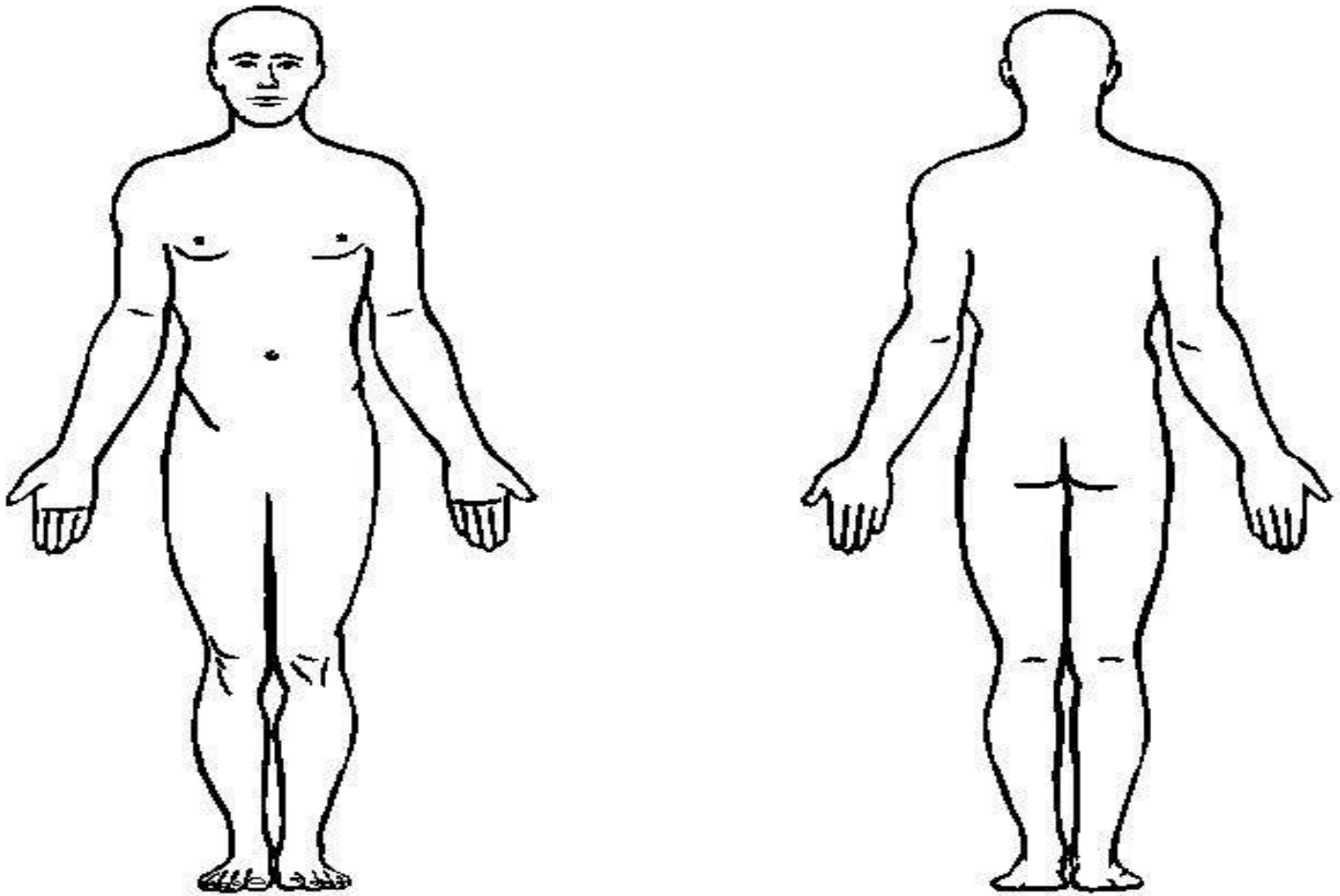
Please list any medications you are taking in these medication categories and any vitamins, minerals or supplements:

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

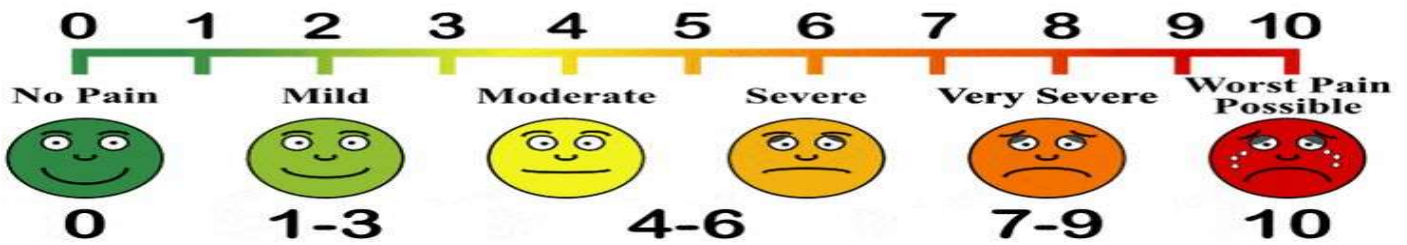
I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I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

Patient/Guardian Signature: _____ Date: _____

Mark your current problem areas on your body.



PAIN ASSESSMENT TOOL



What do you believe to be the cause of your pain? _____

Where is the pain more intense? _____

What makes the pain better / worse? _____

What are your expectations for today's massage therapy? _____

Office Use ONLY:

Post treatment: Are you satisfied with today's treatment? Yes No

How would you rate your pain after treatment? /10

Informed Consent for Low Level Laser Therapy (LLLT)

LLLT is a non-invasive & non-surgical application of laser light. Unlike most other forms of therapy, LLLT is classified as "actinotherapy" in that it results in a chemical and metabolic change of the involved tissues. As a result, LLLT can relieve pain, decrease inflammation, accelerate the healing of tissue (biostimulation), increase blood flow and decrease tissue swelling.

Like all forms of therapy, there are associated risks as well as benefits. Exposure to the eyes during the procedure may result in damage to the retina. Under certain situations a superficial burn of the skin could occur. This is based upon skin pigmentation, skin discolorations (i.e. tattoos), or the use of topical cream, lotions or analgesic balms.

In order to prevent adverse reactions to LLLT, all patients must adhere to the following guidelines:

- Wear approved safety goggles during entire laser treatment session;
- Avoid the use of any topical creams, lotions or analgesic balms before or immediately after treatment;
- Inform the technician of any skin conditions including skin sensitivities to light;
- Clean the area of treatment thoroughly prior to your scheduled appointment.

By signing below I acknowledge that I wish to proceed with LLLT.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING KNOWLEDGE, I KNOWINGLY AUTHORIZE John Chatzigiannidis, TO PROCEED WITH LOW LEVEL LASER THERAPY AND TREATMENT.

Patient Name: _____ Date: _____

Patient/Guardian signature: _____ Age if Minor: _____



If you have had a steroid injection in the last seven days, laser therapy cannot be used at this time.

SIGNATURE

DATE

1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____