Appointment Information and Forms

Below is important information you will need regarding your upcoming appointment. Please call or email if you have any questions prior to your appointment.

- I**ntake Forms:** Please print, complete, and bring the following forms to your appointment. You may also scan and email forms prior to your appointment. Send to info@wholebodypt.com. Please note, even injuries or illnesses that may seem unrelated to your current symptoms are very important for me to know.

- **Location/check in:** Our office is at 1800 Jackson Street, Suite 213, Golden, CO, 80401. Parking and entrance is **behind** the credit union. Please have a seat in the shared waiting room to the left of the entrance upon your arrival. I will greet you there. If you've been waiting more than 5 minutes, please come knock on my door.

- **Rates/Payments:** The standard rate is $135 for 1 hour unless otherwise noted. Progressive Bike Fit Initial Session is $270. (Payment is due at the time services in the form of cash, check (preferred method of payment, made out to Whole Body Integrative Therapies), or credit card. We also accept HSA and FSA cards.

- **Invoices/Insurance:** Whole Body Integrative Therapies is not listed as a provider under any medical insurers, and does not accept medical insurance or Medicare. You may be eligible for insurance reimbursement depending on your **Out of Network Outpatient Physical Therapy** benefits. We will provide invoices for insurance reimbursement, as well as Flexible Spending Account and Health Savings Account reimbursement, upon request.

- **Cancellation Policy:** If you must cancel or change an appointment, we request that you give us **24 hour notice** prior to your scheduled appointment time by calling (720-270-5022) or email (info@wholebodypt.com). There will be a **$50.00** cancellation fee if we are not given 24 hour notice. We appreciate your understanding and cooperation.

- **What to bring/wear**: Bring any relevant medical reports. Bring or wear workout clothes, appropriate shoes - old and new (running/walking/cycling/etc.), and any orthotics. If you are getting a bike fit bring your bicycle with slick tires, any extra parts you have (e.g., stems, saddles, bars, etc), and warm weather riding apparel and clean shoes.

- **Home Exercise Photos**: Many clients have found it helpful to have photos taken of them doing prescribed home exercises during their appointments to ensure memory of proper form/technique. Bring a cell phone or camera to your session if you are interested in having photos available for your personal use.

- **Visual Materials Release**: Whole Body Integrative Therapies frequently videotapes/photographs Client posture and mechanics during appointments, and such materials may be used as Bike Fit, stretching, strengthening and efficiency-related lecture materials. Please advise Whole Body Integrative Therapies if you have any objections to use of your specific visual materials in this fashion. In the event of any Client objections, Whole Body Integrative Therapies will immediately erase such material once the session is completed.

- **PT and PT Student Observation**: On occasion, Whole Body Integrative Therapies has other therapists and students who wish to observe our treatment approach. Please let us know if there would be any concern if they were to observe your appointment.

Thank you and we look forward to helping you!

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What to Expect from Your Bike Fit/What to Bring

Your Bike Fit session will include the following:

1. On-bike analysis – posture, pedaling efficiency, seat, cleat, and handle bar positions
2. Off-bike analysis – flexibility, balance, leg length, extremity and core strength
3. Bike adjustments – matching the bicycle to your body and goals
4. Hands-on treatment of mechanical dysfunctions of the body
5. Exercise instruction – for improvements in cycling efficiency and personal health

A Bike Fit will enable the Client to feel more comfortable on his/her bicycle while riding, **but alone not correct underlying physical issues causing discomfort/pain**. Often, a bicycle's current fit is the large 'final straw' that finishes pushing the body into an unhealthy place. People frequently have underlying musculoskeletal (body) weaknesses (e.g., old injuries, diminished flexibility and joint mobility, core strength, pedaling efficiency) – issues their current bike fit reveals.

A proper Bike Fit can **accommodate** such muscle and joint issues, minimizing or eliminating associated pain/discomfort; **however, the underlying issues remain (with potential to cause problems at a later time**). For example, a chronically tight hamstring due to a restriction at the pelvis and an inhibited core will frequently lead to back and neck pain. By changing a bicycle's fit, such tightness/weakness can be accommodated, allowing the rider to feel better while biking.

However, if the rider does a really hard or long ride, a lot of sitting, lifting or another activity that requires strength and flexibility, the issues (and associated pain/discomfort) may arise again. A Bike Fit that accommodates physical dysfunctions results in the healthiest, but not always the most efficient position (e.g., aerodynamics, power).

As our goal is to help you get into the most efficient position on your bike wight the least amount of accommodations on the bike by restoring optimal motion though out your body.

Therefore, many Clients schedule follow-up appointments to:

1. Recheck and progress their exercises
2. Get additional manual physical therapy work to address areas of mechanical dysfunction
3. Work on proper pedal mechanics on the bike
4. Get further bicycle readjustments based on physical changes (e.g., increased flexibility and strength) that diminish injury as the largest consideration, allowing for more efficient on-bicycle positioning

As part of the Bike Fit appointment, the possibility of follow-up sessions in helping the Client achieve his/her goals will be discussed.

What to bring:

1. **Your bicycle**. For Mountain Bike Fit ONLY: If bringing a mountain bike for this purpose, install a slick (treadless) tire on the bicycle's rear wheel before coming to your appointment. Please bring any extra parts you have: stems, saddles, bars, shoes, orthotics, etc, that you think might be appropriate to be used during the bike fit.

2. **Riding apparel** (e.g., cycling shoes, cycling shorts, short sleeve shirt or tank). If you are changing shoes/cleats, please bring your old pair of shoes.

NOTE: Please ensure cycling shoe cleats are clean/free of debris in the event cleat position adjustments are needed (a nail works well for this purpose).

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Bike Fit Consent and Appointment Information/Policy Information

Please read the following statements carefully and sign at the bottom indicating your understanding. Thank you.

Bike Fit adjustments frequently require a break-in period dependent upon the number and intensity of changes implemented, and amount of time the client rides his/her bicycle once adjustments have been made. Occasionally, downtime, if any, can be minimized or avoided by implementing incremental adjustments until the most efficient rider position is achieved.

1. Bike Fit Checkout List and Health Agreement

- **Bicycle Adjustments:** Bicycle hardware (e.g., brakes, wheels, drive train, fastening devices for seat post/handlebar stem) is loosened/retightened as part of Bike Fit services. Client agrees to recheck any/ all such adjustments to ensure revised bicycle position is secured and safe.

- **Break-In Period:** Break-in period for bicycle adjustments is generally two (2) weeks in duration. During this period, Client will ride the adjusted bicycle using the small chain ring and adjusting riding volume, duration and intensity to below Client's normal levels. Client's original pain/discomfort should not increase during this break-in period. It is somewhat normal to experience differing sensations during break-in, especially muscular ones, but not pain. If Client experiences pain or has questions/concerns, please contact Whole Body Integrative Therapies immediately.

- **Client Agreements:** To the best of my knowledge, I am sufficiently healthy to participate in a Bike Fit appointment and related break-in period, since associated efficiency evaluation requires Client to undergo normal bicycling-related stress. I agree that if at any time I feel discomfort or unsafe during Bike Fit-related activities, I will communicate this to Whole Body Integrative Therapies. I understand that it is my responsibility to notify Whole Body Integrative Therapies of any changes in my medical and/or fitness condition that could impact my ability to exercise and train safely, including (without limitations) changes in matters covered by this questionnaire. I have been advised to consult with a physician before beginning any exercise, including Bike Fit-related activities, even if my answers within this questionnaire do not indicate existence of any specific risk factor(s).

2. Bike Fit Position Change Guidelines:

- Ride on flat to rolling terrain and in easy gears.
- Client should do self-mobilization (foam roller and the like) and daily stretching during transitional period.
- Client should record any changes he/she makes independent of those implemented during bike fit appointment(s).

3. Consent to Evaluation

I hereby consent to the evaluation of my bike fit by a bike fitter/physical therapist affiliated with Whole Body Integrative Therapies.

4. Consent to Treatment

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed by Whole Body Integrative Therapies of its Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization to obtain a current copy of their privacy practices.

5. Consent to Appointment/Policy Information

I hereby accept the terms outlined in **Whole Body Integrative Therapies Appointment/Policy Information** document.

6. Patient/Client Responsibility

- It is the patient's/client's responsibility to inform Whole Body Integrative Therapies of all medical conditions, treatments, and medications at their initial evaluation.

- It is the patient's/client's responsibility to inform Whole Body Integrative Therapies if the patient/client is under the influence of any substance that may affect the safety of their treatment or injure someone else's treatment (drugs, alcohol, blood thinners, etc.).

- It is the patient's/client's responsibility to inform Whole Body Integrative Therapies if the patient/client requires any clarification in understanding terms outlined in Whole Body Integrative Therapies Appointment/Policy Information, and/or provide notice to Whole Body Integrative Therapies of any concerns with these terms in advance of patient's/client's scheduled appointment.

My signature on this form indicates that I have read and understand each of the above patient/client policies of Whole Body Integrative Therapies. I have addressed any concerns I have with these policies with the therapist fitter. I further understand that by not signing this form I may be refused service, as they are essential to the functioning of Whole Body Integrative Therapies.

Signature (Client/Patient or Guardian): _____ Date: _____

Client/Patient Printed Name: _____

Client/Patient phone:_____

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HIPAA NOTICE OF PRIVACY PRACTICES (NOPP)

Purpose: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (NOPP) describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law. Ways your protected health information may be used or disclosed include, but are not limited to, the following:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Alternatively, we may disclose your protected health information to a physician to obtain a referral or prescription authorizing follow-up treatment, if needed.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support business activities of our office and/or your referring physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, practitioner training and licensing, marketing and fund-raising activities. For example, we may disclose your protected health information to physical therapy students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

We may use or disclose your protected health information without your authorization in the following situations (this list is not necessarily inclusive): as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers’ Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when

required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

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HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices (NOPP) or to document our good faith effort to obtain that acknowledgement.

*** You May Refuse to Sign This Acknowledgement***

I, _____, have received a copy of this office's Notice of Privacy Practices (NOPP).

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices (NOPP), but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):
  _____
  _____

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Bike Fit Questionnaire

Date:_____

Name (last): _____(first): _____

Address:_____City_____Zip_____

Best Contact Phone Number: _____ Alternate number: _____

Email: _____ Occupation:_____

Emergency Contact/phone:_____

Date of Birth:_____Age:_____ Height: _____ Weight:_____

Primary Care Physician:_____ Phone:_____

Allied Health and Fitness Providers (chiropractor, orthopedist, pilates instructor, personal trainer, etc)

Provider: _____Phone:_____

Provider: _____Phone:_____

Provider: _____Phone:_____

Provider: _____Phone:_____

Who referred you to Whole Body Integrative Therapies/How did you hear about us? :_____

1. What are your goals and reasons for scheduling a bike fit (e.g., increased comfort, increased efficiency, decreased pain)?

_____

2. What are your goals for this bicycling season?

_____

3. What do you currently like about your bike, if appropriate (e.g., handling, comfort)?

_____

4. What would you change about it?

_____

5. Have you had a previous fit? Date? By whom?

_____

Symptom/Specific Complaint Information

1. Personal history of past injuries: Please describe:

_____

_____

2. Have you had any surgeries? What were they and when

_____

_____

3. Please check and describe if you have experienced any of the following.

_____Numbness/Tingling/Weakness _____
_____ Weight Loss or Gain _____
_____ Fever_____
_____ Shortness of Breath/Cough/Asthma_____
_____ Chest Pain/Heart/Blood Pressure_____
_____ Urinary Tract Infections, Stones _____
_____ Vision/Hearing Loss _____
_____ Skin Lesions or Rash _____
_____ Depression/Anxiety _____
_____ Cancer _____
_____ Gastrointestinal disorders _____
_____ Kidney/Liver/Gallbladder disorders_____
_____ Communicable Disease (Hepatitis, TB)_____

Are there any other medical conditions that Whole Body Integrative Therapies should be aware of?

_____

4. All current medications and supplements:

_____

5. Are you receiving treatment for any other medical conditions?

_____

6. How many hours per week do you exercise?

   a. Biking: _____ b. Running: _____ c. Swimming: _____d. Weights: _____

   e. Other (please describe): _____

7. What changes have you personally implemented with your current bike or bike fit? Did the changes help?

_____

8. Describe your symptoms (please list below with details):

   <u>Ache1:</u>

   a. When did this pain start? How did this pain start? What do you think caused them?
   _____
   _____

   b. What activities bring this pain on? How long can you do that activity before this pain comes on?

   _____

   c. Does it last after activity? With which activities and how long?

   _____

   d. Are there any positions/activities that help ease the pain, e.g., rest, ice?

   _____

   e. Does the pain seem to be aggravated by certain terrains, speeds, or positions?

   _____

f. Since onset are your symptoms better, worse, the same? _____

g. Have you had treatment for this condition in the past? Yes No

If so, what type? _____

Was it helpful? Yes No

h. What is the intensity of your pain? (Please circle)

None 1 2 3 4 5 6 7 8 9 10 Worst imaginable

Ache 2:

a. When did this pain start? How did this pain start? What do you think caused them?

_____

_____

b. What activities bring this pain on? How long can you do that activity before this pain comes on?

_____

c. Does it last after activity? With which activities and how long?

_____

d. Are there any positions/activities that help ease the pain, e.g., rest, ice?

_____

e. Does the pain seem to be aggravated by certain terrains, speeds, or positions?

_____

f. Since onset are your symptoms better, worse, the same? _____

g. Have you had treatment for this condition in the past? Yes No

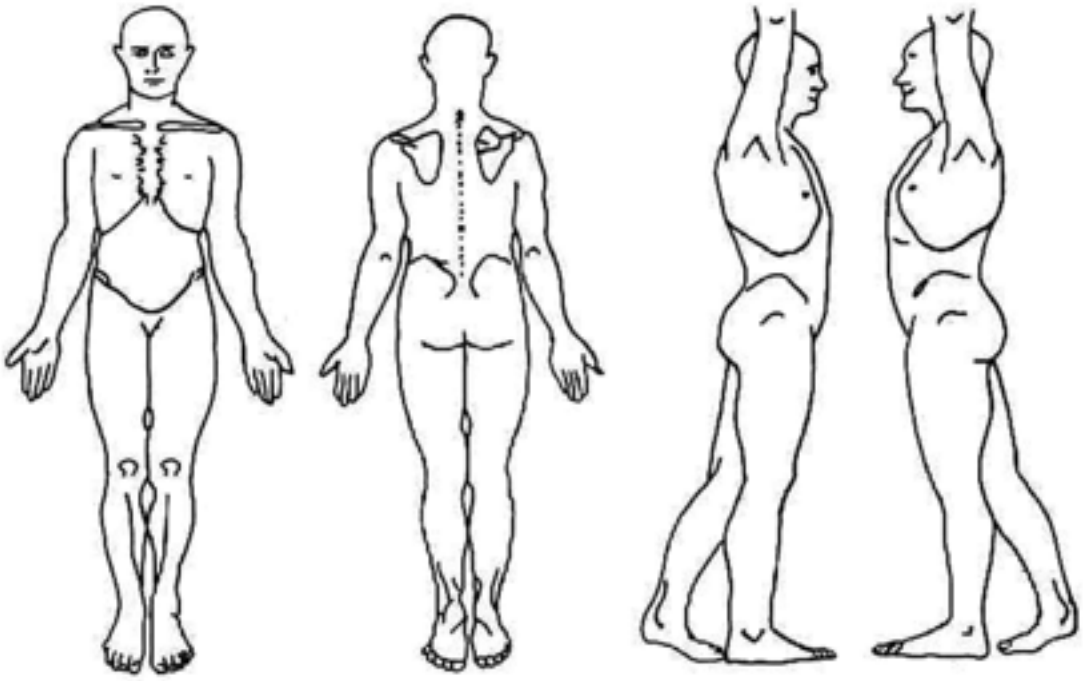
If so, what type? _____

Was it helpful? Yes No

h. What is the intensity of your pain? (Please circle)

None 1 2 3 4 5 6 7 8 9 10 Worst imaginable

Please mark the locations of you pain/symptoms on the diagrams below.



Client Signature: _____ Date: _____