Postural Healing, LLC at Wellness Minneapolis

Confidential Health & Readiness Form

CONTACT INFORMATION

Full Name: _____

Address, City, State, Zip: _____

_____

Cell Phone: _____ Home Phone: _____

E-mail Address _____

Date of Birth: _____ Gender: _____

Height: _____ Weight: _____ Occupation: _____

Emergency Contact, Relationship & Phone Number: _____

How were you referred to Postural Healing LLC? _____

_____

_____

SELF REFLECTION & READINESS TO CHANGE

How much is my health worth to me? _____

_____

In what ways does my lifestyle help reflect that value? _____

_____

In what ways does my lifestyle limit that value? _____

_____

How does pain and/or lack of function limit my ability to live life the way I want and to do the activities that fulfill me?

_____

What does life look like going forward if I chose not to do anything about my current health situation?

_____

_____

Am I an active participant in my wellness? Do I have a plan for improving my current health and for remaining healthy and functional throughout life? How is it working?

_____

_____

What are my greatest strengths? _____

In what areas would I most like to grow? _____

What do I want my life to look like going forward? _____

_____

_____

What steps do I need to take to get there? _____

_____

_____

Do I have a spiritual practice? _____

How do I rate my energy levels on a scale of 1- 10? _____

On a scale of 1-10, how do I rate my daily stress levels? _____

What tools do I use to help manage stress? Are they effective for me? _____

_____

In what areas of my life do I feel most at peace? _____

_____

In what areas do I feel most unsettled? _____

_____

On a scale of 1-10, how ready am I to begin making health and lifestyle changes? _____

GOALS & EXPECTATIONS

What is my primary reason for trying Postural Alignment Therapy? _____

_____

Am I willing to invest time each day to reach these goals? If yes, how much time is realistic for me to stay consistent?

_____

What do I see as the risks and/or challenges involved in committing to and working toward these changes?

_____

_____

What do I see as the reward? Why are these goals important to me? _____

_____

_____

How will I know that I am getting better? List 3 specific goals that I would like reach:

GOAL 1: _____

_____

GOAL 2: _____

_____

GOAL 3: _____

_____

How can my support network best support me in reaching my goals? _____

_____

MEDICAL INFORMATION

What care are you currently under? (Ex: massage, chiropractic, nutritionist, doctor, etc.)

_____

_____

What treatments or healing modalities have you tried in the past for the pain? And did it help?

_____

_____

Please list any Doctors or wellness practitioners you would like me to collaborate with as we move forward together with the Postural Alignment Therapy process.

Provider Name and Number: _____

Provider Name and Number: _____

Provider Name and Number: _____

What have you been told about your symptoms? Do you have a specific diagnosis from your physician? If yes, please describe:

_____

_____

Do you have recommendations or restrictions from your physician? If yes, please explain. _____

_____

_____

What is your instinct telling you about your symptoms? _____

_____

Have you had any past accidents, injuries or surgeries? If yes, please list and describe: _____

_____

_____

_____

Do you currently wear orthotics? _____

Do you currently wear a brace? If so, what part of the body? _____

Do you currently take any medications? If yes, please list medication and dosage. _____

_____

_____

Do you take any supplements or herbs? If so, please list: _____

_____

_____

Do you currently smoke? If yes, packs/day: _____

Do you drink alcohol? If yes, how frequently and typical amount? _____

Do you get headaches or migraines? _____

Do you have trouble with circulation? _____

Do you have difficulty sleeping due to pain? If yes, explain: _____

_____

Do you have difficulty sleeping due to something other than pain? If yes, explain: _____

_____

On average how many hours of sleep do you get each night? _____

Do you snore and/or have you been diagnosed with sleep apnea? _____

Do you have trouble breathing? _____

Do you have any allergies? _____

_____

Do you have frequent constipation or loose stools? If so, which: _____

What are your typical eating habits? _____

_____

_____

How many 8 ounce glasses of water do you drink each day? _____

What other beverages do you drink on a daily basis (soda, juice, coffee, etc.)? _____

_____

What are your current day to day activities? _____

_____

Do you have trouble with balance? _____

Do you have any concerns, questions or hesitations about participating in Postural Alignment Therapy?

_____

_____

Body Chart

Please mark areas of pain or limitations & include the following for each symptom:

Describe type of pain (Ex: Numbness, Tingling, Burning, Stabbing, Aching, Cramping, Sensitive/Tender, Inflammation, Other)

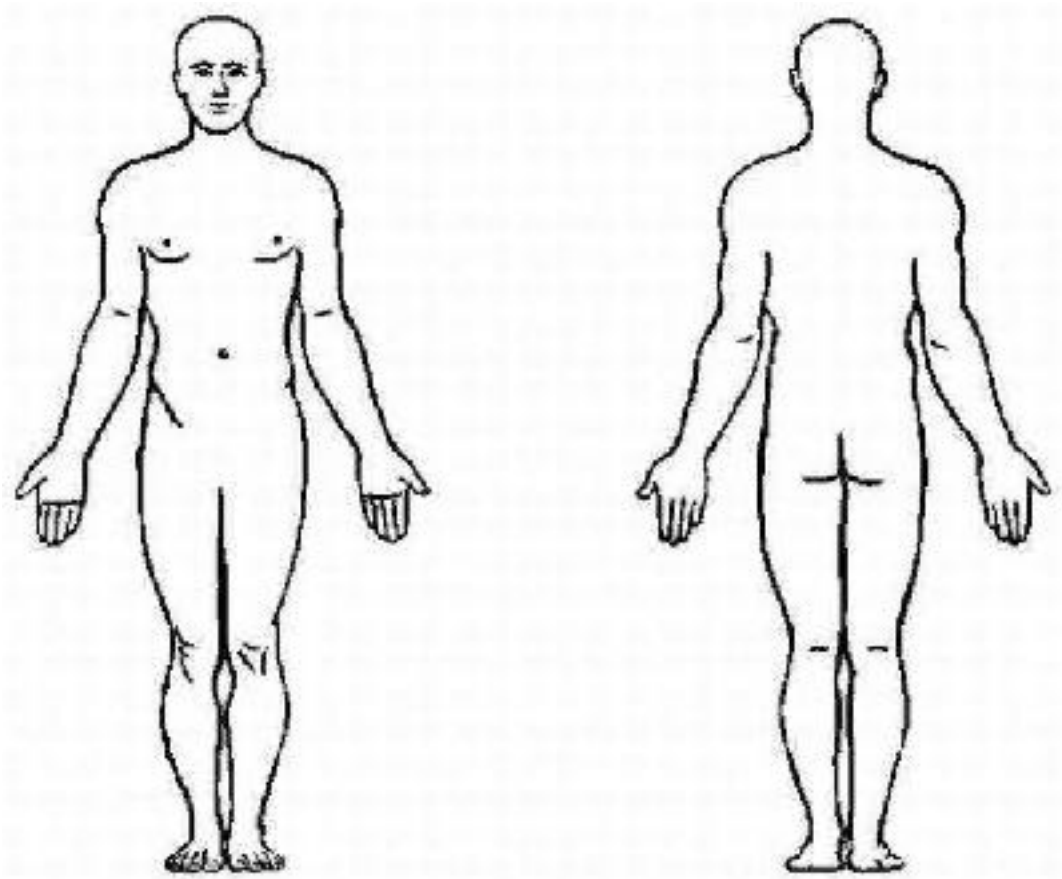
Severity (0-10)

Onset (When do you notice the pain begin? What things trigger the pain? Ex: Is the pain worse in the morning and better later in the day or is the pain better in the morning and worse later in the day?)

Duration (How long does the pain last?)

What makes the pain feel better?

What makes the pain feel worse?



I declare that the above information is true and accurate to the best of my knowledge.

CLIENT NAME: _____

PARENT/GUARDIAN (if under 18 years of age): _____

CLIENT SIGNATURE: _____

TODAY'S DATE: _____

Program Agreement

24 hour cancellation policy

Arrive on time to ensure that you get the most out of our time together.

Payment due upon arrival.

Responsibility for your health & Commitment to the program

Clients are required to show a strong desire to take responsibility for their own health. Commitment to the program includes keeping appointments, arriving on time, completing exercises daily, listening to signals given by his/her body and keeping open communication. The goal is to become empowered to take charge of your health.

Open Communication/Constant Dialogue

You know your body better than anyone. Only you can feel what is going on inside you. In order for me to give you the best possible tools, I need to understand what you are feeling throughout the program. I welcome e-mails anytime with questions, concerns, updates, etc.

Postural Alignment is NOT a quick fix

It is a process that requires daily work and consistency on the part of the client.

The Body is a unit

Postural alignment does NOT focus on specific symptoms; rather it looks at restoring function in the body. Rarely is the source of pain the actual cause of pain.

Education

We learn together as we go. Each body responds differently. Communication is a key to making this process work more efficiently.

Recommend reading: The Egoscue Method of Health Through Motion by Pete Egoscue

Acknowledge change and progress

Pay close attention to your body during this process. Progress will show up in many forms including but not limited to: improved posture, decreased and/or eliminated pain, increased range of motion, improved balance and flexibility, increased body awareness, increased function in all the bodies systems. Acknowledge yourself for investing in your health. Our bodies are amazing gifts. They are the vehicle that enables us to give back to others and to do all of the things we love.

Restore, Strengthen, Maintain

The absence of pain does NOT indicate the end of the postural alignment process.

Requirements for Success:

_____ Do the exercises everyday

_____ Communicate

_____ Regular visits (this is a process)

I have read, understand, & agree to the expectations of this program. I am ready & willing to take responsibility for my health & resolve to work toward positive health changes.

_____

Client's Name (Print)

_____ _____

Client's Signature Date

CLIENT INFORMED CONSENT

Welcome to Postural Healing, LLC ("Postural Healing"). Clients of Postural Healing are asked to review and sign this agreement, so that they understand the terms and conditions of services. For good and valuable consideration, the sum and sufficiency of which are hereby acknowledged, the parties agree as follows.

MISSION

The mission of Postural Healing, LLC is to improve the lives of participants by coaching them to reduce and eliminate chronic pain and to improve function and performance.

BACKGROUND & QUALIFICATIONS

Anna Forliti is an Egoscue Certified Postural Alignment Specialist with training in the following areas:

(a) Egoscue Certified Postural Alignment Specialist & Advanced Exercise Therapist

(b) Certified Affiliate of The Egoscue Method®
(c) Professional Fitness/Wellness Coaching certification from LifeTime Academy (d) Certified Personal Trainer with the National Academy of Sports Medicine (e) Corrective Exercise Specialist with National Academy of Sports Medicine (f) Performance Enhancement Specialist with National Academy of Sports Medicine

PRACTITIONER DISCLOSURE

Although your provider, Anna Forliti, has recognized training, services are provided under the title Complementary and Alternative Health Care Practitioner. According to Chapter 146A of the Minnesota Statues, services are considered an unlicensed complementary and alternative health care practice and it is important to note the following: THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS.

PRACTITIONER LIMITATIONS

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture

practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

THERAPEUTIC APPROACH

Postural Alignment Therapy uses gentle corrective exercises to return the body to its natural anatomical position by realigning the eight major load joints. When in balance the body will naturally begin to regenerate and heal itself. The result is reduced or eliminated pain and increased overall function. Postural alignment Therapy focuses on restoring the cause of pain rather than treating the symptoms. Rarely is the site of pain the actual cause of pain.

DISCLAIMER

While services are therapeutic in nature they are not provided under the context of traditional medical treatment. Services are not intended to be used as or to replace medical treatment. Clients exhibiting significant medical issues will be referred for medical health treatment and may be required to participate in traditional services in order to continue working with their practitioner.

TREATMENT

1. Postural Alignment Therapy is a process that retrains the muscles to perform the actions they were created to do. It is not a quick fix. Postural Alignment Therapy requires a series of sessions designed to gradually move my body back to my design posture.

(a) The purpose of this and subsequent visits to Postural Healing is to acquire the education and tools to manage Client's own health through Postural Alignment Therapy. A natural and conservative approach to health goals, Postural Alignment Therapy utilizes exercises to rebalance the body to help prevent and eliminate musculoskeletal pain.

(b) Many variables and specific individual sets of circumstances will determine the length of therapy. Any success with this method requires that the Client take responsibility for their own health and do their exercise menu on a daily basis, as provided by the trainer.

(c) Client is responsible for monitoring their own condition throughout the process and shall communicate with the Provider any questions, concerns, to monitor progress, or to discuss symptoms that might appear, change or disappear. Communication is an essential part of the Postural Alignment Therapy process.

(d) Even with specific safeguards, procedures and policies in place there is a remote possibility that harm may befall Client.

CLIENT WARRANTIES AND REPRESENTATIONS

Client warrants and represents that they are free of any medical restrictions and able to engaging in active or passive exercises.

Postural Alignment Therapy is a process that retrains the muscles to perform the actions they were created to do. It is not a quick fix. Postural Alignment Therapy requires a series of sessions designed to gradually move my body back to my design posture.

LIMITAITONS OF LIABILITY

(a) Client assumes full responsibility for any and all injuries or damage which may occur to them using the Services. Postural Healing shall not be liable for any damages arising from any personal injuries sustained by the Client on or about the premises of Postural Healing. A Client utilizing the Services does so at their own risk.

(b) Client fully and forever releases and discharges Postural Healing, its owners and employees from any and all claims, demands, damages, rights or action or cause of actions, present or future, whether the they are currently known or unknown, anticipated or unanticipated, resulting from or arising out of a their use or intended use of the Services, except in those cases where the gross negligence of Postural Healing has been proven.

(c) Postural Healing shall not be liable for the loss of, theft of, or damage to any personal property of Client.

(d) IN NO EVENT SHALL POSTURAL HEALING HAVE ANY LIABILITY TO CLIENT FOR ANY CONSEQUENTIAL, SPECIAL, PUNITIVE OR INDIRECT LOSS OR DAMAGE WHETHER OR NOT ANY CLAIM FOR SUCH DAMAGES IS BASED ON TORT OR CONTRACT OR POSTURAL HEALING KNEW OR SHOULD HAVE KNOWN THE LIKELIHOOD OF SUCH DAMAGES IN ANY CIRCUMSTANCES.

RELEASE OF LIABILITY CLAUSE

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless, Anna Evans, from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

LENGTH OF TREATMENT

The length of treatment is dependent on the specifics of each client's treatment goals and current level of functioning. During the initial sessions client goals and frequency of treatment is discussed. The initial session is for 2 hours and each follow-up session is 1 hour.

TERMINATION OF TREATMENT

The provider reserves the right terminate treatment at their discretion for reasons including but not limited to the following: untimely fee payment, noncompliance or failure to appropriately participate in treatment, conflict of interest, failure to participate in services, or when the client's needs are outside the scope of practice or competence of the therapist. Clients also have the right to terminate treatment at their discretion.

CONSULTATION

At times third party consultation is utilized to discuss client work in order to enhance the quality of services provided. During such consultation neither the full name of the client nor any of their specific information that could be used to identify them will be disclosed. Any concerns or questions regarding the process of consultation may be discussed at any time.

CONFIDENTIALITY

The content of client sessions are confidential. Only your provider and their Business Associates will have access to your Private Health Information. No identifying information will be released without your written consent (i.e. a signed release of information form) or in the case of a minor without the written permission of his/her parent or legal guardian.

EXCEPTIONS TO CONFIDENTIALITY

(a) If you are having a medical emergency that requires crisis intervention by a third party.

(b) If you commit a crime on your provider's premises or against your provider, your contact and/or any relevant health information will be disclosed to the appropriate authority.

(c) If you initiate a malpractice lawsuit, any information relevant to the lawsuit will be disclosed.

MINORS

Sessions with clients who are minors (under the age of 18) require a parent or guardian to be present during all sessions.

AVAILABILITY

Sessions are made by appointment only. However, you may leave a message for me at any time on my confidential voicemail. When leaving a voicemail please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Phone calls are returned during normal workdays (Monday through Friday) typically within 24 hours.

LOCATION OF SERVICES

Services are provided in-office or online via Skype.

FEE & PAYMENT INFORMATION

Postural Healing is a fee-for-service provider and sessions are charged per visit type. Fees are adjusted periodically and clients will receive a 60-day notice when fees are adjusted. Detailed below are fee policies and rates.

(a) LATE ARRIVAL FEE POLICY: If clients arrive late, they will receive the remainder of their session time at the full fee. This is necessary so that other clients are seen at their scheduled times.

(b) RESCHEDULING OR CANCELATION FEE POLICY: Client hereby agrees to this Rescheduling or Cancellation Policy. Reschedules and Cancellations must be made 24 hours before the scheduled appointment. Otherwise, the Client shall pay the full amount due as if they took part in that scheduled session at the normal rate for that session. For illness or other emergencies arising the same day, exceptions for fees will be made at the discretion of the provider. Notice of reschedule or cancellation must be made to Postural Healing by email through your client portal or by phone to 612-282-7707.

(b-1) Adherence this Policy is the responsibility of the Client and such adherence will avoid the Client having to pay for a session they did not attend. All sessions fees are non- refundable once Services have been provided, or in the event of non-adherence to the Cancellation Policy.

(c) NO SHOW FEE POLICY: Clients who do not show for a scheduled appointment will be charged the full amount due for their scheduled session.

(d) FORMS OF PAYMENT: Payments in the form of cash, checks, and credit card are accepted.

(e) RETURN CHECK POLICY: Clients who pay via check and have their payment returned due to insufficient funds will be charged a return check fee. Clients will be allowed 2 returned checks before paying via check will no longer be an acceptable form of payment for their future services/fees.

(f) FEE SCHEDULE: Fees are the direct responsibility of each individual client and payment in full is due prior to the start of every scheduled session.

CLIENT BILL OF RIGHTS

Consumers of Complementary and Alternative Health Care services have the right to the following:

(a) To report complaints to the Office of Unlicensed Complementary and Alternative Health Care Practice, Health Occupations Program, Minnesota Department of Health at P.O. Box 64882 St. Paul, Minnesota 55164;

(b) To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;

(c) To be free from exploitation for the benefit or advantage of their provider; (d) To privacy as defined by rule and law;

(e) To be informed of the cost of services before receiving the services and reasonable notice of changes in services charges;

(f) To have access to their records as provided in Minnesota Statutes, section 144.292;

(g) To change providers after services have begun, within the limits of health insurance, medical assistance, or other health programs;

(h) To have reasonable notice of changes in services and coordinated transfer when there will be a change in their provider of services;

(i) To receive referral information about other service providers who may be available in the community;

(j) To assert client rights without retaliation.

INFORMED CONSENT AND ACKNOWLEDGMENT OF AGREEMENT

I have considered the above information before selecting to receive services for myself or child for whom I am legally responsible. I have obtained whatever additional information or professional advice I consider necessary to make an informed decision. The choice to participate in services has been made of my own free will and I know I have the right to discontinue services at any time. I agree to take full responsibility for myself or my child/s self-care in the physical, emotional, mental, and spiritual dimensions of my/their life

Client has been fully informed and fully understands the postural alignment therapy services, facilities, and equipment of Postural Healing, LLC, (collectively "Services") and requests and consents to those Services in an attempt to improve their physical condition. Client agrees to abide by all rules and regulations now in force by Postural Healing for the use of Services, and as may be modified from time to time. I understand and acknowledge the following:

(a) I have read this form in its entirety and agree to the terms detailed in this document. (b) I have been given a copy of this document and may request a copy at any time.

(c) I have been given the opportunity to ask any questions regarding services and the terms detailed in this document.

(d) I agree to pay all fees associated with my client account to Postural Healing in keeping with the agreement's fee policies.

(e) I understand the limitations of confidentiality.
(f) I agree and consent to receive services under these conditions.

SIGNATURE

By signing below I'm stating that I fully understand and agree to the terms in the agreement detailed above. In addition, my signature on this form acknowledges my choice to consent to the services approaches that my provider offers. My consent is free from pressure or influence from any person or group.

PRINT NAME * _____

CLIENT SIGNATURE : _____

DATE (mm/dd/yyyy) : _____

WELLNESS MINNEAPOLIS
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