Release Of Liability & COVID-19 Risk Acknowledgement

In consideration of being allowed to participate in any way in the Pilates Sante program, related events and activities, the undersigned acknowledges, appreciates, and agrees that:
There is a risk of injury from activities involved in this program, and while particular rules, equipment and personal discipline reduce the risk, the risk does exist; and

1. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases or others, and assume full responsibility for my participation; and
2. I willingly agree to comply with the stated and customary terms and conditions for participation. If however I observe any unusual hazard during my participation, I will remove myself from participation; and
3. I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while attending Pilates Santé and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Pilates Santé may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Pilates Santé employees, clients, and patients. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury, expense or liability to myself due to COVID-19 exposure and or contracting of disease.
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless the Pilates Sante agents and employees, other participants, and owners and lessors of premises used to conduct the event ("releasees"), with respect to all and any injury, disability, death, or loss or damage to person or property, whether arising from the negligence of the releasees or otherwise, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

_____

PRINTED NAME PARTICIPANTS SIGNATURE. DATE

FOR PARENTS/GUARDIANS OF PARTICIPANTS OF MINORITY AGE (UNDER 18)
This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release, as provided above, of all releasees, and for myself, my heirs, and next of kin, I release and agree to indemnify and hold harmless the releasees from any and all liabilities incident to my minor's child's involvement or participation in these programs as provided above, even if arising from their negligence, to the fullest extent permitted by law.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Pilates Sante Payment Policy: I understand that Pilates Sante payments are due at the time of service and are nonrefundable and nontransferable.

Pilates Sante Insurance Policy: I understand that I am responsible for all interactions with my insurance company. I understand that Pilates Santé is an **out of network provider**. Pilates Santé will provide the necessary superbill/invoice paperwork. However, I acknowledge that I am responsible for all interactions with my insurance company.

I understand that Pilates Santé is not a **Medicare** provider. Effective 1/11, changes to Medicare regulations prohibit submission of claims to Medicare for services rendered by providers, such as Pilates Santé, who are not enrolled with Medicare. I understand that I am responsible for 100% of the cost of my services, and that these expenses are not to be submitted to insurance.

Pilates Sante Cancellation Policy: I understand that If I do not give a minimum of 24 hour cancellation notice I will be charged the full fee of my pilates session.

Pilates Sante Observation Policy: I understand Pilates Sante is a teaching facility, so I may be observed by students and potential instructors during a session at any time.

Pilates Sante Photo/Video Policy: I understand that Pilates Sante staff may take still photos and/or video during sessions.

_____

PRINTED NAME PARTICIPANTS SIGNATURE. DATE

Direct Access Disclosure

You (the patient) are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist. With your written authorization, your physical therapist shall notify your physician and surgeon, if any, that he/she is treating you.

_____ _____

Patient Signature Date

PILATES SANTE
15951 LOS GATOS BLVD, #4
LOS GATOS, CA 95032

HIPAA Information and Consent Form

By signing this form, you are granting consent to PILATES SANTE to use and disclose your protected health information (PHI) and electronic protected health information (EPHI) to a third party provider for the purposes of treatment, payment, and health care operations. PILATES SANTE will not disclose PHI/EPHI to a third party without your consent.
The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

We have adopted the following policies:

- Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
- You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- Your therapist will share information that is on your chart when you are referred to one of the physical therapists or pilates instructors.
- Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- Under California law, you may continue to receive direct physical therapy treatment services for period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California
- Do you consent to allow PS to take photos and/or videos during your session for marketing uses? YES ____ NO _____

Signature:
_____
Printed Name:
_____Date:_____
Other person/provider/entity you would like your PHI/EPHI disclosed to:
Name:
_____
Relationship:
_____

Client Intake

1. Name:_____ Date:_____/_____/_____
2. Date of Birth: _____/_____/_____ Age:_____
3. Cell Phone:_____
4. Home Phone:_____
5. Emergency Contact: Name/Phone_____
5. Email:_____
6. Home Address:_____
7. How did you find out about Pilates Santé?_____
8. Why are you taking Pilates?

_____

9. What are your fitness or rehabilitative goals?

_____

10. What do you think has limited your ability to achieve these goals so far?

_____

11. How often do you exercise? What type of exercise?

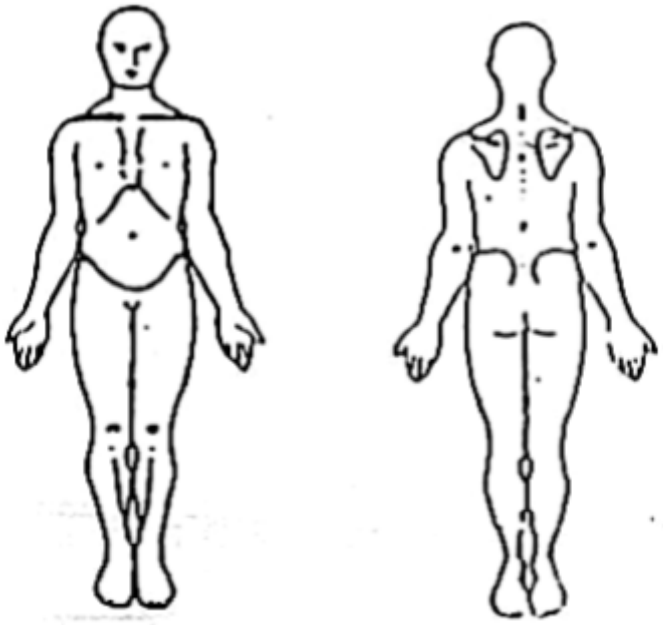
_____

12. What are the physical demands of your occupation or daily activities? (ex:.sitting, standing, driving)

_____

13. Do you have any current injuries? No / Yes (explain). If yes, please mark on body below.

_____



14. What are the biggest problems your injury has caused you?

_____

15. Are you under medical care for these injuries? No / Yes
    Physician/Chiropractor/Therapist names:_____

16. Other medical conditions or diagnoses?

_____

17. What medication are you taking, if any?

_____

18. What kind of program or treatment do you think you need?

_____

19. Do you have any concerns or questions?

20. Do you have a history of:

Diabetes	No	Yes
Glaucoma	No	Yes
Gastric reflux	No	Yes
High blood pressure	No	Yes is it under control? _____
Surgery to your head, neck or spine	No	Yes_____
Abdominal surgery	No	Yes_____
Shoulder injury	No	Yes_____
Knee injury	No	Yes_____
Ankle injury	No	Yes_____
Wrist injury	No	Yes_____
Fractures	No	Yes_____
Osteoporosis or Osteopenia	No	Yes
When was your most recent bone density test?_____ Were the results: mild / mod / severe?		
Rheumatoid arthritis	No	Yes
Osteoarthritis	No	Yes
Are you currently pregnant?	No	Yes
Cancer	No	Yes_____