InsideOut
BODY THERAPIES

NAME _____ DATE OF BIRTH___/___/___

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (home) _____ (work) _____ (cell) _____

REFERRING PHYSICIAN _____ PHONE NUMBER _____

DIAGNOSIS _____ INJURY DATE _____

EMAIL: _____

* Would you like to be included in emails regarding general studio updates? □ YES □ NO

EMERGENCY CONTACT: _____PHONE NUMBER_____

HOW DID YOU HEAR ABOUT *INSIDEOUT BODY THERAPIES*? _____

DO YOU HAVE BCBS INSURANCE? □ YES _____ □ NO
(member ID number)

CONSENT TO TREAT

I, _____, consent to treatment as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

CONSENT TO DISCLOSE

I, _____, authorize InsideOut Body Therapies, LLC practitioners and instructors to share my protected health information as it pertains to the course of my treatment and healthcare.

AUTHORIZATION FOR OWED BALANCES AND LATE CANCEL FEES

I, _____, hereby authorize InsideOut Body Therapies ("IOBT") to charge the indicated credit card for services rendered by IOBT in accordance with the IOBT Fee Schedule and Studio Policies. **I understand that IOBT will file any insurance claims on my behalf, however if said claim is denied, I acknowledge that I am responsible to pay the balance owing for said service.** If IOBT is unable to process my payment, I will be responsible for an alternate payment arrangement and all late fees that occur. IOBT will notify client with an account statement prior to any charges to credit card. I understand that this agreement shall remain in force unless I cancel it in writing. I will not dispute IOBT's charges to my credit card so long as the amount in question is for services rendered and/or part of studio late cancel and no show policy. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement with IOBT. I acknowledge that I have read and agree to all of the above terms and conditions.

_____ _____
Signature of Credit Card Holder (Required) Date

Per the Health Insurance Portability and Accountability Act (HIPAA), this information is strictly confidential.

CANCELLATION POLICY

We honor and respect your time and our service to you is our highest priority. In return, we ask that you also respect our schedule so that we may be available not only to service you, but to also service others. InsideOut Body Therapies has a **24-hour cancellation policy** for all scheduled appointments. There will be a charge of **$50**, billed to the patient for each instance a patient does not show for a scheduled appointment or does not give at least 24-hour cancellation notice. Payment will be required before or at the time of your next scheduled appointment. Thank you for your understanding of this policy, as this helps us to serve you and our other clients more promptly and efficiently. **Please Initial and Date** _____