

**Bradley Wellness, LLC**  
**patient information and financial policy \_\_\_\_\_ Bradley Wellness**

My mission is to provide a superior level of care which encompasses treating the body as a whole. The goal is to resolve not only your symptoms to the greatest extent possible, but also to eliminate the source of the problem and educate you in self-care techniques to minimize or eliminate future recurrences of the same problem. After you are discharged from physical therapy you can progress your level of function and health by participating in my maintenance and wellness programs which include, but are not limited to, gyrotonic exercise, pilates exercise and wellness coaching.

I have elected to provide physical therapy on a “fee at time of service” basis. Since I am not a preferred provider with insurance companies, I do not have to limit the time or quality of treatment I provide because of insurance company restrictions or elevate my rates to pay for billing services. Additionally, I have the flexibility to assist patients in financial need.

**Prior to your first scheduled appointment, call your insurance company to completely understand your physical therapy benefits.** At the time of service and payment, you will receive a written statement which you can submit to your insurance company for their consideration of reimbursement to you. I will be happy to provide chart notes or other documentation at your, or your insurance company’s, request. The amount of reimbursement you receive will vary according to the terms of your insurance policy. Some companies may reimburse you at 80%, some at 60%, some at 40%, and some may not reimburse you at all. I cannot make guarantees or estimates regarding what reimbursement your plan allows.

I accept cash or check at the time of service. My fees are based on time spent with you and the treatments performed during your appointment. The fee ranges are as follows:

- \$175 for the initial session
- \$150.00 for 60 minute appointments
- \$75.00 for 30 minute appointments

If you have any questions, please feel free to contact me. I look forward to working with you.

Sincerely,

Kelly Bradley, MSPT, CNC, CHHC, RYT, CPI  
Licensed Physical Therapist  
Bradleywellness.com, kelly@bradleywellness.com  
202-320-5025

## **conditions, informed consent and waiver of liability \_\_\_BradleyWellness**

I understand that I am a patient of Kelly Bradley, MSPT who is an independent Physical Therapy practitioner. My care is the exclusive responsibility of Kelly Bradley, MSPT.

### **Cooperation with Treatment:**

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with Kelly Bradley.

### **Cancellation Policy:**

I understand that all physical therapy treatments are by appointment only. If I must cancel a scheduled appointment I will call at least 24 hours in advance to allow you to fill the time slot. I understand that if I cancel less than 24 hours in advance, I will pay the fee for my scheduled session.

### **No warranty:**

I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that Kelly Bradley will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

### **Informed consent for treatment:**

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. Kelly Bradley provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

**Potential risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact Kelly Bradley.

**Potential benefits:** I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

**Alternative:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

### **Waiver of Liability:**

This release, Waiver and Hold Harmless Agreement is made by and between the undersigned and Bradley Wellness, LLC / Kelly Bradley, and entered into on the day, month and year noted below.

1. Participation in Physical Therapy, Gyrotonic exercise, Pilates exercise, Yoga, movement therapy, therapeutic exercise and general exercise could lead to physical injury to the patient.
2. Patient desires to undertake Bradley Wellness' / Kelly Bradley's program with the full knowledge of the possibility that physical injuries could result from it and desires to assume the risk of any such injury.
3. The parties recognize that Bradley Wellness / Kelly Bradley will not be able to and will not provide its program to clients without the execution of this agreement.

Therefore, patient, in consideration of the above and of the physical therapy and exercise sessions to be provided, hereby waives all claims for damage or loss to person or property which may be caused by any act, or failure to act, of Bradley Wellness / Kelly Bradley. Patient assumes the risk of all dangerous conditions in and around the premises and waives any and all specific notice of the existence of such conditions. Patient also assumes the risk of any and all injuries that might result from participating in Bradley Wellness / Kelly Bradley's physical therapy and exercise programs.

In consideration of my participation in Bradley Wellness / Kelly Bradley's physical therapy and exercise program, I, \_\_\_\_\_, hereby release Bradley Wellness / Kelly Bradley, from any claims, demands and causes of action arising from my participation in the physical therapy and exercise program. I hereby affirm that I have read and fully understand the above, am over eighteen years of age or am a legally emancipated minor.

**Release of medical records:**

I authorize the release of my medical records to the following physicians/primary care provider or insurance company; \_\_\_\_\_

\_\_\_\_\_

**Financial and insurance responsibilities:**

I agree to pay for my treatments at the time of service by cash or check unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand Kelly Bradley will provide me with a receipt that is my responsibility to submit to my insurance company.

I have read the above information and I consent to physical therapy evaluation, treatment and exercise.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or guardian signature

\_\_\_\_\_  
Kelly Bradley, MSPT/Date

**patient information** \_\_\_\_\_ **Bradley Wellness**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Ph# \_\_\_\_\_

**lifestyle information** \_\_\_\_\_ **Bradley Wellness**

Occupation: \_\_\_\_\_ Currently working: Y / N

What physical demands does your job require? \_\_\_\_\_

How many hours per week do you work? \_\_\_\_\_

How many hours per day do you sit in front of the computer? \_\_\_\_\_

Is your work space set up ergonomically correct? \_\_\_\_\_ please explain \_\_\_\_\_

Hobbies: \_\_\_\_\_

Dietary preferences/restrictions: \_\_\_\_\_

Sample of daily menu:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

What type of exercise do you engage in? \_\_\_\_\_

How often? \_\_\_\_\_

Duration and Intensity per session? \_\_\_\_\_

If you could do any type of exercise, what would you do? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you use caffeine? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you use any other mind-altering substances? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Current prescribed medications you are taking: \_\_\_\_\_

\_\_\_\_\_

Current vitamin or supplements you are taking: \_\_\_\_\_

Allergies (of any type): \_\_\_\_\_

How would you rate your general well-being at this time? Please elaborate. \_\_\_\_\_

Do you participate in a healthy lifestyle? \_\_\_\_\_

Would you like to learn how to live a healthier lifestyle? \_\_\_\_\_

What specific wellness topics are you interested in learning more about? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**current medical information** \_\_\_\_\_ **Bradley Wellness**

Do you have a written prescription from a physician? Y N

Physician who wrote the prescription: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Who can I thank for referring you? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Other practitioners: (physicians, surgeons, physical therapists, healthcare practioners, chiropractors, massage therapists, personal trainers, nutritionists, etc)

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for seeing him or her: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for seeing him or her: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for seeing him or her: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for seeing him or her: \_\_\_\_\_

\_\_\_\_\_

Reason for current visit. Please describe in detail the problem that brought you here:

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Date of injury or onset of symptoms: \_\_\_\_\_

Is it getting worse, better or staying the same? \_\_\_\_\_

What caused your injury or condition? \_\_\_\_\_

Have you had any medical testing related to this problem? Please list results: \_\_\_\_\_

Have you had any previous treatment for this problem? If so, please explain: \_\_\_\_\_

Do you have pain? If yes, what location? \_\_\_\_\_

Please rate your pain on a scale from 0 (none) to 10 (agonizing) at its:

best: \_\_\_\_\_ worst: \_\_\_\_\_ now: \_\_\_\_\_

Please list all activities of daily living that are impacted by your condition: (showing, dressing, cooking meals, walking up stairs, etc) \_\_\_\_\_

Please list all work activities that are impacted by your condition: (sitting at the computer for extended time, specific work duties, amount of time can tolerate at work, etc) \_\_\_\_\_

Please list all recreational activities that are impacted by your condition: (hobbies, sports, activities with kids, etc) \_\_\_\_\_

Besides your chief complaint, do you have any other physical complaints or problems at this time, or complaints that are recurrent in your life? \_\_\_\_\_

Are you currently being treated by any other healthcare practitioners?

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for seeing him or her: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for seeing him or her: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for seeing him or her: \_\_\_\_\_

Have you been treated by a Physical Therapist this year? Y or N

Physical Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

List all medications you currently take:

**medical history** \_\_\_\_\_ **Bradley Wellness**

Please list all medical conditions, surgeries and past injuries (even if you think it is not related):

Please list all medications you have previously taken and for what? Why did you stop taking the medication?

**current goals** \_\_\_\_\_ **Bradley Wellness**

What are your current goals for physical therapy? What do you hope to achieve? \_\_\_\_\_

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**making appointments** \_\_\_\_\_ **Bradley Wellness**

All physical therapy treatments are by appointment only. If a scheduled appointment must be cancelled, please call me 24 hours in advance. This allows me time to fill your slot or rearrange my schedule. If appointments are broken less than 24 hours in advance you will be charged your session fee. I sincerely appreciate your cooperation.

-Please be on time for your appointments. If you are late I reserve the right to shorten your treatment time or, cancel your appointment and charge you the fee for your session.

-I strongly recommend that you schedule as many appointments in advance as possible. Appointments are booked on a first come, first serve basis.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

## medical health questionnaire \_\_\_\_\_ Bradley Wellness

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming more physically active.

If you are planning to become much more physically active than you are now, start by answering the questions below. If you are between 15-69 years of age, the questionnaire will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly:

Check **yes or no**

### questions \_\_\_\_\_ yes no

- 1) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- 2) Do you feel pain in your chest when you do physical activity?
- 3) In the past month, have you had chest pain when you were not doing physical activity?
- 4) Do you lose your balance because of dizziness or do you ever lose consciousness?
- 5) Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- 6) Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- 7) Do you know of any other reason why you should not do physical activity?

If you answered **YES** to one or more of these questions. Talk with you doctor by phone or in person **BEFORE** you start becoming more physically active or **BEFORE** you have a fitness appraisal. Tell you doctor about the questionnaire and which questions you answered **YES**.

-You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

-Find out which community programs are safe and helpful for you.

If you answered **NO** honestly to all the questions you can be reasonably sure that you can:

-Start becoming more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.

-Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

#### **Delay becoming much more active:**

-If you are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better: or

-If you are or may be pregnant – talk to your doctor before you start becoming more active.

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**PLEASE NOTE:** If your health changes so that you then answer **YES** to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

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**additional questions** \_\_\_\_\_ **yes** **no**

- 8) Have you ever had a history of respiratory or lung problems?
- 9) Are you currently on any medications that directly affect the heart, lungs or Circulatory system (ie. Blood pressure medication)?  
If yes, please list \_\_\_\_\_  
\_\_\_\_\_
- 10) Do you have high cholesterol?
- 11) Do you know what your cholesterol scores are?  
Total cholesterol? \_\_\_\_\_  
HDL? \_\_\_\_\_
- 12) Do you have a chronic illness or condition?
- 13) Do you have a hernia, or any condition that may be aggravated by lifting weights?
- 14) Do you smoke? If yes, how many packs a day? \_\_\_\_\_
- 15) Have you had surgery within the past 12 months?
- 16) Do you have a thyroid problem?
- 17) Are you currently pregnant or have been within the past 3 months?

If you have answered YES to any of the above questions, please explain below and have your physician complete the Physician Release form on the following page. Also, please list any information that you feel I should know before setting you up on an exercise program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person to be contacted in case of emergency: \_\_\_\_\_  
Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

I understand this Medical History Questionnaire serves as a preliminary screening resource to assist professionals in the determination of client risk to exercise. If the information above indicates an increased risk for exercise, I authorize Bradley Wellness, LLC and Kelly Bradley to contact my physician for approval and recommendations for my exercise program. If I am at risk and have not received medical clearance, I understand I cannot engage in any sessions or physical therapy test or treatment or receive recommendations from Kelly Bradley. I will participate in private sessions aware of my risk and may seek only instructional advice from Kelly Bradley. I agree that Bradley Wellness, LLC and Kelly Bradley shall not be liable for any injuries or damages arising from private sessions or use of studio equipment. If client is under 18 years of age, this consent must be signed by a Parent/Guardian.

**signature** \_\_\_\_\_ **date** \_\_\_\_\_