Authorization for Treatment & Payment

My signature below verifies that I have requested this evaluation, treatment and/or training and I have been informed of the Privacy Practices for Be Your Best Consulting, LLC dba 4x4 Healing. I understand that:

I may receive a one-time, free, 30 minute structural screening. If treatment and/or training are provided, I verify that I requested these services from Bonnie Yost, P.T., and will be responsible for payment at time of service.

Cancellations: I understand that I need to cancel my appointment at least 24 hours *prior* to my appointment or I will be charged for my scheduled appointment.

I understand that Bonnie Yost, P.T., dba **Be Your Best Consulting, LLC dba 4x4 Healing**, will not be involved in billing insurance or third-party payees. Private-pay 4x4 Healing care is charged at $200/hour. Upon request, charged at a rate of $250/hour for insurance billing & physician notes, statements will be provided to me for insurance reimbursement. Payment is due as services are rendered. Checks, cash, VISA, Discover and MasterCard are accepted methods of payment.

If I am able to prepay, I will receive a **FREE** session of equal length/value for every four (4) same-length sessions that I prepay. I can use paid time in 15-minute segments up to 90 minutes per session, for structural correction/rehabilitation, self-care and preventive training, stress management, 4x4 Healing life-skills training, or combination treatment, training and care.

I understand that this authorization will be in full effect until revoked in writing by me.
_____ *Medicare and Medicaid are not billed or involved with any aspect of these services.*
Initial: _____

LEGAL WAIVER and INFORMED CONSENT

I, the undersigned, confirm that I have requested physical therapy treatment, care from Bonnie Yost, PT, dba **Be Your Best Consulting, LLC dba 4x4 Healing** and/or other training course(s) from Bonnie Yost, PT, and/or Dennis Yost (firearms training), **Be Your Best, Consulting, LLC dba 4x4 Healing**. I understand that comprehensive and sensitive physical/manual therapy, and some movements, positions, and activities related to health and physical therapy care and training may elicit physical, emotional, and other reactions and responses in me. I understand that I can proceed at my own speed and discontinue treatment, training and care at any time. ***I understand that it is my responsibility to communicate my needs to my care providers and instructors*** and that other resources are available to support my needs outside of this setting.

❑ I, _____ (Initial)____, authorize 4X4 HEALING to use training and activity photo, video and audio recordings of me, without compensation, to share God's work in my life and for 4X4 HEALING promotions and marketing.

I, _____ agree to release, indemnify and hold harmless in every respect Bonnie Yost, PT, and/or Dennis Yost, volunteers, assistants, and all care givers, **Be Your Best Consulting, LLC dba 4x4 Healing** from any and all claims of fault, liabilities, costs, expenses, demands or lawsuits arising out of, related to or connected with BYB/4x4 Healing care, training, activities, and my presence on, and use of the Yost property, and/or other training facilities and premises. I also waive for myself and all who may represent me (such as executors, personal representatives, administrators, assignees, heirs or family relations) any and all claims of liability, loss, injury, illness, demands, damage to myself or my property, legal and financial responsibility of Bonnie Yost, PT, and/or Dennis Yost, **Be Your Best Consulting, LLC dba 4x4 Healing** along with all employees, contract employees, volunteers, associates, families, heirs and persons connected in any way to these entities and the work, training, and care of Bonnie Yost, PT, and/or Dennis Yost, **Be Your Best Consulting, LLC dba 4x4 Healing**, including unattained expectations, discovery at any time of emotional, mental, physical or other issues and/or any sequelae, misuse of information, instruction or equipment, disclosure of information and/or due to the effects and results of the work and care provided by Bonnie Yost, PT, and/or Dennis Yost, all associates and representatives of **Be Your Best Consulting, LLC dba 4x4 Healing.** I understand that this instrument is intended to be as broad and inclusive as permitted by law, along with any and all omissions of me, the undersigned, and that if any provision of this agreement is held invalid or otherwise unenforceable, the enforceability of the remaining provisions shall not be impaired thereby. No remedy, and each and every remedy shall be cumulative and shall be in addition to every other remedy now or hereafter existing at law or in equity or by statue or otherwise. The election of anyone or more remedy hereunder by Bonnie Yost, PT, and/or Dennis Yost, **Be Your Best Consulting, LLC dba 4x4 Healing** shall not constitute any waiver of the right of Bonnie Yost, PT, and/or Dennis Yost, **Be Your Best Consulting, LLC dba 4x4 Healing** to pursue other available remedies. This instrument binds me, the undersigned, and all representatives, executors, administrators, assignees and family to full responsibility and waives and indemnifies Bonnie Yost, PT, and/or Dennis Yost, **Be Your Best Consulting, LLC dba 4x4 Healing** in every way for my participation in all aspects of the work, training, care and activities of **Be Your Best Consulting, LLC dba 4x4 Healing.**

I, the undersigned, have read this release, waiver and assumption of risk agreement and I understand its terms. I voluntarily and expressly accept all risks and responsibilities of participating in the activities, training, instruction and care of Bonnie Yost, PT, and/or Dennis Yost, **Be Your Best Consulting, LLC dba 4x4 Healing.** I further acknowledge and agree to abide by all firearms, range, barn, activity, procedure, safety rules and any other rules and procedures stated by Bonnie Yost, PT, and/or Dennis Yost, **Be Your Best Consulting, LLC dba 4x4 Healing.** All of my questions have been answered satisfactorily.

As I have requested this care and/or training, I assume all responsibility and risk in participating in treatment, training and activities. I understand my responsibility to pay for services rendered at the time of service and that my compliance in physical therapy treatment/training and with my independent program is critical to lasting benefit and improvement.

Name (PLEASE PRINT): _____ **Date:** _____

Signed: _____ **DOB:** _____ **M F**

Last Revised 2020

Privacy Practices Notification
& Authorization for Release of Information

Bonnie Yost, PT, **Be Your Best Consulting, LLC dba 4x4 Healing** along will all staff, contract employees, volunteers, associates, heirs and everyone connected in any way to these entities and this work are committed to protecting your confidential information. *Our policy is to avoid personal identification in written and verbal communication.* Your permission will be requested when, in the interest of your care and best good, any coordination of care and consultation are needed with your other care providers. We will work with your desires as much as possible. In case you become a life threat to yourself or others, you will be informed of our intent to communicate with appropriate authorities.

At any time, you have the right to submit a complaint or praise in writing to Bonnie Yost, PT. It is impossible to correct problems that we do not recognize, so we thank you for letting us know how we can improve our services to you. You will suffer no repercussions in any way for reporting dissatisfaction.

Other health care providers are working with me: YES NO

I understand these privacy practices and all my questions have been answered satisfactorily. I hereby give my permission for Bonnie Yost, PT to discuss, send and receive file information and coordinate aspects of my treatment, care, plan, condition, etc. with **my providers**:

PROVIDER

Name **Phone** **Specialty**

_____

I, _____, am voluntarily signing this document and I understand that this authorization will be in full effect until revoked in writing by me. I understand that I may revoke this authorization (by giving written notice) at any time. I verify that all my questions have been answered acceptably and that I have carefully read the pages of this agreement.

PLEASE PRINT clearly:

Patient Name: _____ DOB:

_____

Patient SSN: _____

Insurance Holder SSN: _____

Insurance Holder Name:

_____

Address:

_____Zip:_____

Home Phone: _____ Work Phone: _____

cell: _____

Signed: _____ Age:_____ M F Date: _____

Witness: _____

Date: _____

Patient Information

THANK YOU for completing this information so that we can coordinate efforts to meet your goals when we begin working together. I am thrilled that you won't "settle" but are stepping into healing and better health—inside and out! I am eager to meet you and journey with you.

Patient Name: _____

DOB: _____

Email Address:

_____

Mailing Address:

_____Zip:_____

Home Phone: _____ Work Phone: _____

cell: _____

Signed: _____ Age:_____ M F

Date: _____

What are your concerns, pains, or problems and when did they start?

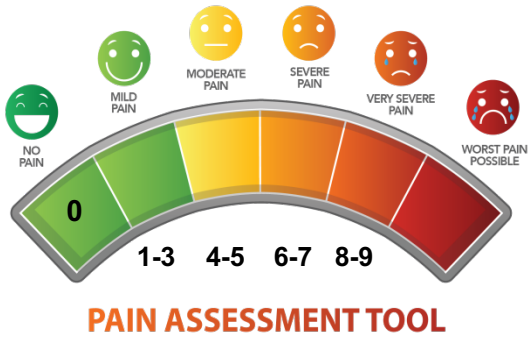
Please rate your pain— 0→10 (X/10) and area:

Area(s) of Pain: _____

_____

_____

10



Please indicate if you have any of these conditions:

- ❑ Pregnancy: Due date: _____ ❑ Cancer: area:_____
- ❑ Blood clots—Medication:_____ ❑ Hemophilia
- ❑ History of blood clots/blood thinners—date: _____ ❑ Skin diseases:_____
- ❑ Pacemaker ❑ Electrical implant
- ❑ Heart problems:_____ ❑ Multiple Sclerosis
- ❑ Tumors/cysts/ lumps: area: _____ ❑Infection:_____ ____
- ❑ Tendon or muscle tears:_____ ❑ Osteomyelitis
- ❑ Arteriosclerosis problems:_____ ❑ Circulatory
- ❑ Loss of feeling/numbness:_____ ❑ Previous PT: _____
- ❑ Other health concerns:_____

Are you taking any medications? Please list name, dosage, and frequency:

What are your goals? What do you hope to get from your *4x4 Healing* sessions?

Please list and describe anything that you cannot do now that you were able to do before and that you want to be able to do:

What is your current Activity Level?

type of activity: _____frequency: _____duration: _____

Have you had any trauma or surgeries in the last 2 years? NO YES Please explain:

Have you experienced abuse or domestic violence? NO YES Please tell me at what age and anything else that you want me to know.