Natalie Dowty, PT, MPT, EdD
integrative wellness, inc., physical therapy & consulting
Wellness based rehab for chronic conditions.
68th and Grover, Omaha, NE, 68106 • integrativewellnesspt.com • (402) 212-7444

INFECTIOUS DISEASE INFORMATION & SCREENING

Thank you for choosing Integrative Wellness, Inc., Physical Therapy and Consulting.

Integrative Wellness, Inc., PT continues to be committed to your health and safety. At this time, the CDC recommends that all infection and prevention control protocols continue for health care settings and for those who are immunocompromised. Here is what to expect at your next clinic appointment:

- You will be asked screening questions before your appointment and when you're in the office. Please review the questions below. If the response is YES to any of them, PLEASE NOTIFY ME BEFORE YOU ARRIVE.
- Your temperature will be taken upon your arrival.
- You will be asked to wash your hands or to use hand sanitizer when you enter the clinic.
- The waiting area will no longer offer magazines, or shared items since these items are difficult to disinfect.
- I will be wearing a mask, gloves and/or other appropriate protective equipment, during your visit.
- You will be required to wear a clean mask at all times while in the office. If you arrive without a mask I will gladly provide one for you.
- A new air conditioner and HEPA air purifier have been installed in the clinic space.

These procedures are designed to create the safest environment for you and other patients, from COVID-19, and from other infectious disease. I look forward to seeing you. Please feel free to call with questions.

Sincerely,
Dr. Natalie Dowty, PT, MPT, EdD

I have read the above information and I consent to the procedures. I attest that my responses to the screening questions below are true.

NAME:_____ DATE: _____

Screening Questions

	YES	NO
Are you fully vaccinated?		
Have you had close contact with anyone with acute respiratory Illness? Or have you traveled outside of Nebraska in the past 14 days or within 14 days of your scheduled visit?		
Do you have a confirmed case of COVID-19 or have you had close contact with a confirmed case of COVID-19, flu or other infectious illness?		
Do you have any of the following symptoms in the past 48 hours: • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Difficulty breathing • Sore throat • Difficulty swallowing • Chills • Headaches • Decrease / loss sense of smell • Unexplained fatigue/malaise / muscle aches • Nausea/vomiting, diarrhea, abdominal pain • Pink eye (conjunctivitis) • Runny nose/nasal congestion - no known cause		
If you are 70 years of age or older, are you are experiencing any of the following symptoms: delirium; unexplained or increased number of falls; acute functional decline; or worsening of chronic conditions?		

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INFORMED CONSENT AND OTHER ACKNOWLEDGMENTS

Thank you for choosing Integrative Wellness, Inc., Physical Therapy and Consulting.

Please initial each item and then sign at the bottom.

By signing this document, I, the undersigned patient/client, or authorized representative consent to and authorize treatments, examinations, medical services, procedures, training and/or consultation, and I acknowledge and consent to the following:

_____1. AUTHORIZATION FOR RELEASE OF INFORMATION **(BC-BS SUBSCRIBERS ONLY)**

I am covered by Blue Cross-Blue Shield (BCBS). I authorize Integrative Wellness, Inc. to release all necessary information to BCBS of Nebraska, which is responsible for paying for my care. I authorize and direct BCBS NE to pay all benefits due for such care directly to Integrative Wellness, Inc. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Integrative Wellness, Inc. and to BCBS, signed and dated by me. Such revocation shall not be effective for information released and/or charges incurred prior to revocation.

_____2. PAYMENT FOR SERVICES

I agree to pay for services rendered by Integrative Wellness, Inc. to me or for my benefit. For private pay or those with out-of-network insurance benefits, payment in full is due at the time services are received. If Blue Cross-Blue Shield of Nebraska is the health insurance provider, fees due at the time of service include the copay (usually 10-30% of the fee) and any unmet deductible. Integrative Wellness, Inc., will send an itemized bill for each session to Blue Cross-Blue Shield of Nebraska in accordance to reasonable and customary charges for such services.

_____3. CANCELLATION POLICY

If it is necessary to cancel your scheduled appointment, **PLEASE CALL OR TEXT 402-212-7444 BY 9 A.M., ONE WORKING DAY IN ADVANCE OF YOUR APPOINTMENT.** Otherwise, you will be charged the full fee of the session. Your timely cancellation gives another person access to medical care. If you do not reach Dr. Dowty, leave a voice mail or text message. Please **DO NOT EMAIL YOUR CANCELLATION**. Do not come to clinic when you are ill. When illness results in a late cancellation, Integrative Wellness, Inc. will waive the late fee. Integrative Wellness, Inc. reserves the right to suspend services after three late cancellations in a calendar year.

_____4. INFECTION CONTROL

I agree that I will not come to Integrative Wellness, Inc, when I am ill. I agree to provide proof of COVID 19 vaccination, or to get specific accommodations from Integrative Wellness Inc in advance of my visit. I will not come to clinic if I have any of the following symptoms of the flu, COVID 19, or other infectious disease in the past 5 -7 days, including, fever, cough, sore throat, nausea/vomiting, diarrhea, abdominal pain with no known cause, pink eye (conjunctivitis), runny nose/nasal congestion - no known cause, decrease / loss sense of smell**.** Please call the clinic as soon as possible to reschedule. I understand I may be required to answer screen questions, have my temperature taken, wash my hands, use hand sanitizer and to wear a clean mask while in the clinic. If I arrive without a mask, one will be provided for me. If I am concerned about whether to come to clinic, I will call in advance to ask questions.

_____5. ALLERGY SAFETY

Due to severe allergies, I will not bring nuts or peanut products into the clinic. I agree to remove food oils from nuts or peanut products before entering clinic by washing your hands with soap and water (Purell will not remove the oil). I will also avoid the use of fragrance and essential oils.

_____6. MEDICARE BENEFICIARIES

If I am a covered by Medicare, I understand that Integrative Wellness, Inc. is not a Medicare provider and has no relationship with Medicare. This means that Integrative Wellness, Inc. can provide fitness training and wellness consulting services on a self-pay basis. These services are as "non-covered" and are not reimbursable by Medicare.

_____7. AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS

I authorize and release Integrative Wellness, Inc. and its agents to take photographs, videos, or other photographic, electronic images of me. Such images may be used for educational or other purposes to facilitate learning and treatment goals. These images may be maintained as part of my record. My confidentiality will be maintained.

_____8. AUTHORIZATION AND RELEASE FOR EMAIL AND TEXT MESSAGING

I authorize and release Integrative Wellness, Inc. and its agents to communicate with me via email and text message. Such communication may be related to education, physical therapy or consulting. If I wish Integrative Wellness, Inc. to stop electronic communication, I will email my request to: drndowty@gmail.com

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_____9. VALUABLES
I hereby release Integrative Wellness, Inc. from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment. Integrative Wellness, Inc. assumes no responsibility for loss or damage to any of my personal property.

_____10. DISCLAIMER REGARDING RESULTS
While patients/clients get excellent results at Integrative Wellness, Inc., Integrative Wellness, Inc. cannot guarantee any specific result(s) of any examination, treatment, procedure, medical care, consultation or training. Achievable goals and expectations will be individually assessed.

_____11. WAIVER / RELEASE OF LIABILITY
The philosophy of Integrative Wellness, Inc. is to prescribe exercise and activity in a gentle and painless manner. However, all physical therapy activities involves some risk. I UNDERSTAND AND ACKNOWLEDGE THAT THE PHYSICAL THERAPY ACTIVITIES IN WHICH I MAY ENGAGE AS PART OF TREATMENT PROVIDED BY INTEGRATIVE WELLNESS, INC. INVOLVE INHERENT RISKS. These risks include minor strains, injury, increased pain, fractures, other ailments that, could in rare circumstances, cause serious disability or death. I RELEASE, AND HOLD HARMLESS from any and all liability or fault and promise not to sue, Integrative Wellness, Inc. or any of its employees, directors, students and volunteers (and their families).

_____12. ACTIVE PARTICIPANT - ASKS QUESTIONS
I understand that my active participation is a part of successful treatment. If I have questions regarding any of the various types of diagnostic/treatment procedures, exercises and/or interventions that may be recommended, I will ask my therapist/consultant to provide me with additional information. It is the goal of Integrative Wellness, Inc. to help me be more independent in managing my wellness. I understand that if I do not take a an active role in the agreed-upon plan of care, Integrative Wellness, Inc. may discontinue or reduce the frequency of my visits.

_____13. PROVIDE ACCURATE AND THOROUGH INFORMATION
I understand that the healthcare professionals involved in my care rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining recommended treatment and exercise prescription. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making and/or exercise prescription. I will notify Integrative Wellness, Inc. at my next visit if

- There is a change in my health status.
- I am or become pregnant.
- I change my medications or start taking new ones.
- I am experiencing any pain, side effects or difficulties

_____14. CONSENT TO TELEHEALTH / VIRTUAL CONSULTATION
I consent to engage in telemedicine consultation with Integrative Wellness, Inc., Physical Therapy. I certify and understand:

- the difference between video conferencing consultation and direct in-person care.
- potential benefits and risks of technology. Risks include unauthorized access and technical difficulties.
- the telemedicine visit can be discontinued by either party at anytime.
- billing will occur from my practitioner at the time of service.
- I had/have the opportunity to ask questions about telehealth to my satisfaction.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete. In addition, signing this form indicates that (a) I have had the philosophy of the program explained to me or I have read the integrativewellnesspt.com website, (b) I have freely decided to participate in a therapy or a training program at Integrative Wellness, Inc., and (c) I consent to evaluation and treatment/training by Natalie Dowty, PT, MPT, EdD.

A copy of this document may be utilized the same as the original.

_____ Date: _____
Patient/Parent/Guardian/Authorized Representative
If not signed by the patient, please indicate relationship to the patient on the line below:

_____