

## **Wellspring Structural Integration**

Karen Daniels, OTR/L  
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Bend, Oregon 97703  
(541) 330-0302

Welcome! You have taken the first step towards becoming more in touch with your body, and bringing new alignment, flexibility, and balance to it.

### **What is Structural Integration?**

Structural Integration is an integrated system designed to recondition the whole body. It is a process in which people are moved from their current state to an optimal state of health and well being. This optimal state of health is the body's "normal" and natural condition.

Although Structural Integration is often effective for temporary pain or tension relief, we recognize that pain and tension is usually the result of an overall pattern of imbalance occurring in the body. Rather than treating the pain or tension "symptom" of this imbalance, structural integration focuses on rebalancing the entire body, returning it to a more aligned, relaxed, and youthful state.

On a physical level, structural integration addresses the connective tissue or more specifically, the fascial system. Fascia is a plastic-like tissue that wraps all muscles, individual fibers, and bundles of individual fibers that become muscle. It comes together at the ends of muscle to become tendons. It also encases all the bones, nerves, blood vessels, organs, etc. in the body and is continuous from head to toe. Because of this network of connections, stress or injury in any area of the body has an effect on every other part of the body. For instance, tension in the connective tissue of the leg pulls the tissue throughout the torso.

In its optimal condition, fascia is loose, moist tissue. When there is continual free movement and balance in the body, the fascial body stocking remains loose and mobile, facilitating the movement between different parts of the body. However, under continual stress and restricted movement, fascia becomes rigid and loses its fluidity. Layers of fascia begin to glue to one another, causing the "knots" you may have experienced in your back and neck. The sheaths of fascia stick in a systematic way, based on our habitual patterns of movement, or more correctly, lack of movement. Although people most often associate tension and stiffness with their muscles, it is actually the connective tissue that accumulates much of this stress.

Reconditioning the body after it has gone through this rigidification requires not only releasing the rigidity from the connective tissue, but also bring awareness to and changing the patterns that caused the tissue to rigidify in the first place. Connective tissue bodywork, movement education, and body awareness are the main components of my work and work together to produce long lasting changes.

**What should I Wear?**

I typically work with people in their underwear, but if you are uncomfortable with this, bring shorts and also for women, a bra or two-piece swimsuit (no one-piece swimsuits). Please do not wear perfume or cologne.

**Miscellaneous...**

Your session will be an hour long. Payment is due at the time of service. If I will be billing your insurance, your co-payment is due at the time of service.

Your appointment is scheduled for \_\_\_\_\_ at \_\_\_\_\_  
Please give me at least 24 hours prior notice if you need to cancel or change your appointment.

I am looking forward to working with you!

Karen Daniels

Wellspring Structural Integration

Karen Daniels, OTR/L

541-330-0302

New Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Tel#: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

(Please circle preferred contact number) Email: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex:  Male  Female Social Security# \_\_\_\_\_

Your Dr.'s Name? \_\_\_\_\_

Student: Y N Full Part-time Marital Status (please circle one) M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse or Parent's: Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Person responsible for payment on this account: \_\_\_\_\_

Insurance Information

Are you covered by Medicare? Yes No Please be advised that this office is NOT contracted with Medicare/Medicaid.

Do you have any group, union or personal health and accident insurance?  Yes  No

Name of Insured: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ Policy# \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group # \_\_\_\_\_ ID #(if any) \_\_\_\_\_

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

Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Additional Insurance Company (if any): \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ Policy # \_\_\_\_\_

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

Please complete the following important information.

Is your condition due to an accident? Yes No If no, then what was the Date of onset? \_\_\_\_\_

If yes please complete the following : Date of Accident: \_\_\_\_\_ State \_\_\_\_\_

Were you involved in an / automobile accident / work related accident / other (Please circle one)

Were you recently hospitalized? Yes No If yes, When? \_\_\_\_\_

Who may I thank for referring you to my office? \_\_\_\_\_

Have you had or are you currently having other body work? Yes No If yes, where and when? \_\_\_\_\_

Read Carefully and Sign Below

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree to allow Wellspring Structural Integration to bill my insurance company as a courtesy, permit the release of records necessary to process my claims, and authorize payments to be made directly to Wellspring Structural Integration for treatment rendered. I further understand that co-payments and payments applied toward deductibles are due at time of service. I also agree to authorize Wellspring Structural Integration to represent me before the Oregon Insurance Commissioner if needed.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guarantor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Payment Policy**

I can accept only clients paying their own fees in full, or those for whom insurance payment is guaranteed. I am unable to accept Medicare or Medicaid assignments.

If you are not covered by insurance, I need your payment in full (cash or check) at the time of your office visit. If insurance covers only a portion of the cost of your treatment, as is often the case, please pay your portion at the time of your office visit, and I will bill your insurance company for the remainder.

A rebilling charge of \$5.00 per month will be assessed to unpaid balances of 60 days or more.

I hope you understand that the payment policy is necessary to assure the financial resources needed to maintain the quality of care in this office.

**Appointment Policy**

All appointments are agreements, and respect for these agreements is vital to the success of our work together. Please cooperate by taking the responsibility for confirming your next appointment time, and by being here when scheduled, or by communicating if you will not be able to make your appointment.

If you fail to keep an appointment without *24 hours prior notice*, I will charge you for the scheduled time. Your cooperation supports and enhances the work of therapy. I look forward to working with you.

Karen Daniels, OTR/L

I understand and agree to the above payment and appointment policy.

Signed \_\_\_\_\_

Date \_\_\_\_\_