



Dear Sir or Madam:

Thank you for your interest in *the* Feldenkrais Foundation's Low Fee Clinic. This popular clinic provides individual *Feldenkrais Functional Integration* sessions at a reduced rate for those who cannot otherwise afford treatment. Appointments are available Wednesday afternoons from 2-5pm and Saturdays from 11am-3pm at the Feldenkrais Institute of New York, in a comfortable, professional setting.

Please complete the following Low Fee Clinic Application in order to help us determine your eligibility for this program. This is a needs-based Clinic with rates determined on a sliding scale, ranging from \$35.00 to \$75.00 per session. Please complete each section of the Application found on pages 1-6 of this document, and submit the two additional documents that are required to support your financial information. This includes a copy of the page from your most recent Tax Return listing your AGI (Adjusted Gross Income) and a copy of your last pay stub. We will be unable to review your application if it is incomplete.

Once your application has been reviewed and your eligibility has been determined, we will contact you about your application's status. If you are approved, we will send a Participant Contract for you to sign and return to the Feldenkrais Foundation before your sessions are scheduled. Please note that contracts are six months. After six months, clients will need to fill out an additional session request form in order to be eligible to continue in the Low-Fee Clinic.

Completed applications can be submitted either by mail or email to:

[rebecca@feldenkraisfoundation.org](mailto:rebecca@feldenkraisfoundation.org)

Rebecca Teichera  
Subject: Low Fee Clinic Application  
134 W 26<sup>th</sup> St, 2<sup>nd</sup> Floor  
New York, NY 10001

If you have any questions about the application process, please contact me, at 212-727-1210.

We look forward to serving you.

Be Well,

A handwritten signature in black ink that reads "Rebecca Teichera".

Rebecca Teichera  
Programs and Operations Manager  
THE FELDENKRAIS FOUNDATION  
134 W 26<sup>th</sup> St, 2<sup>nd</sup> Floor  
New York, NY 10001

## PERSONAL INFORMATION

First Name, Middle Initial	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Street Address	City, State	Zip Code
Home Phone	Work Phone	Cell Phone
Email Address		Date of Birth
Do you have a Primary Care Provider? Circle one:    Yes    or    No                      If <b>Yes</b> , what is their name and contact information?		

## EMPLOYMENT & FINANCIAL INFORMATION

Are you currently employed?                      Circle one:    Yes    or    No                      Are you a (circle one):    Dancer    Actor    Singer If <b>Yes</b> , what is your occupation and/or where are you currently employed?	
What was your <b>total household income</b> for the <b>2018 tax year</b> ?    Filing Status:    Married    or    Single	
What is your <b>current</b> monthly household income?	What is the total number of dependents in your household?
Please provide us with any additional information describing you financial circumstances that may influence our decision.	

## ATTACHMENTS

In addition to completing the entire application, please submit the following attachments along with your application.  
**Please note that both attachments are required and your application cannot be processed until they are received:**

- One copy of the page from your most recent Tax Return listing your AGI (Adjusted Gross Income) for the tax year
- One copy of your last pay stub

**ADDITIONAL INFORMATION**

Is this your first experience with the <i>Feldenkrais Method</i> ?      Circle one:    Yes    or    No  If <b>No</b> , where and how have you experienced the <i>Feldenkrais Method</i> ?
What is your main reason for seeking treatment?
Was there a specific incident that caused your issue or concern?
Have you sought medical assistance?      Circle one:    Yes    or    No  If <b>Yes</b> , what was the result or recommendation?
Have you ever been hospitalized or have you had any surgical procedures related or unrelated to this issue?
What conditions, activities or situations seem to make the problem worse?
Are you currently taking any medications or receiving psychiatric treatment? If so, please specify.
Is there any other information you'd like to share with us?

## REFERRAL INFORMATION

How did you hear about us?
Have you previously received Functional Integration sessions at the <i>Feldenkrais Institute New York</i> ? Circle one:    Yes    or    No  If <b>Yes</b> , which Practitioner did you see?
Have you previously received physical therapy treatment at <i>Physical Therapy &amp; Feldenkrais, NYC</i> ? Circle one:    Yes    or    No  If <b>Yes</b> , which Physical Therapist did you see?

## EMERGENCY CONTACT

First Name, Middle Initial	Last Name	Relationship
Street Address	City, State	Zip Code
Home Phone	Work Phone	Cell Phone

## APPOINTMENT REQUEST INFORMATION

Please check off the times blocks below that you wish and are available to attend Low Fee Clinic sessions.

### Low Fee Clinic Hours

Wednesdays	<input type="checkbox"/> 2-5pm
Saturdays	<input type="checkbox"/> 11:00am-3:00pm

## LOW FEE CLINIC POLICIES

- **Payment:** Due at the time of service.
- **Scheduling:** We recommend scheduling 2-3 weeks in advance to ensure the most convenient time for you. If no appointment is available, upon your request we will put your name on the waiting list and notify you when an appointment becomes available.
- **Cancellation Policy:** We require **24 HOUR NOTICE** for any cancellation as we exclusively reserve that

## LOW FEE CLINIC APPLICATION

appointment time for you and would like to offer the appointment to another patient if you are not able to keep it. Please allow ample time for public transportation or inclement weather. A **\$35-\$75 cancellation fee** will be applied to appointments cancelled or broken without 24 HOURS NOTICE based on your session rate. If you cancel **TWO (2)** times with less than 24 hours notice your contract will be voided. You may reapply after 6 months.

- **Rates & Time Period:** Session rates are determined on a sliding scale from \$35.00-\$75.00 per hour. For your maximum therapeutic benefit, these sessions must be used within a six month time period. You are welcome to apply for additional sessions once you reach the end of the time period. A new application must be submitted 1 year following the date of your first application.
- **About the method:** Feldenkrais is a movement-based method of learning; all Low Fee Clinic practitioners are certified by the Feldenkrais Guild of North America. Based on the findings of the initial session, your practitioner will determine the best course of action for your treatment. This plan may help clarify postural alignment, patterns of movement and self-use. Such movement lessons may be performed by the student following verbal instructions or through gentle hands-on work. The practitioner may work with areas of the body other than the specific site of injury or pain. If you experience discomfort, physical or otherwise, please inform the therapist or administrative staff without delay. Your comfort is one of the necessary conditions for learning more optimal ways of moving and the overall success of the treatment.

## TREATMENT AUTHORIZATION

By signing below, I certify that all the information I have submitted is true. I understand that any incorrect, incomplete or false information I provide could result in the termination of this application.

I have read and understand the Low Fee Clinic policies.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## ACKNOWLEDGEMENT OF CANCELLATION POLICY

*Functional Integration* appointments broken or cancelled by the client **without at least 24 hours advance notice will incur a late cancellation fee.** The signature below confirms that I have read, understand and agree to comply with the cancellation policies regarding *Functional Integration* with the Low Fee Clinic as listed on page 4 of this Application.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**WAVIER, RELEASE OF LIABILITY & ASSUMPTION OF RISK**

In consideration of being permitted to participate in activities at The *Feldenkrais* Foundation, Inc.'s "Low Fee Clinic ("LFC") and to participate in the described activities of *Functional Integration*<sup>®</sup> ("FI") and *Awareness Through Movement*<sup>®</sup> ("ATM"), and workshops wherein FI and ATM are part of a program of *Feldenkrais Method*<sup>®</sup>-related activities,

I, \_\_\_\_\_, in full appreciation of the risks inherent in such activities, do hereby covenant not to sue, and hereby waive, release and forever discharge The Feldenkrais Foundation, Inc., its directors, officers, agents, and employees, from and against any and all claims, demands, actions or causes of action, for costs, expenses or damages to personal property, or personal injury, loss, or liability which may result from my participation in the aforesaid activities.

I acknowledge that my participation in the above described activities is voluntary. I also understand that there is no guarantee of a successful outcome and that it is possible, although rare, that an increase in discomfort may result from such participation.

I understand the following: The *Feldenkrais Method*<sup>®</sup> is a movement-based method of learning. *Feldenkrais* is an educational modality and is not a substitute for medical advice or treatment. During the session, the practitioner may work with areas other than the specific site of injury or pain. If you experience discomfort, physical or otherwise, inform the practitioner without delay. Comfort is one of the necessary conditions for learning more optimal ways of moving and for the overall success of the lesson.

**I have read and understood the Waiver and Release of Liability & Assumption of risk above:**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

*Any person under the age of 18 years or otherwise legally disabled must have a parent or guardian co-sign this form:*

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_