Personal Training & Physical Therapy, Inc.

(Please Print Clearly)

Today's date:				SSN #:
PATIENT INFORMATION				
Last Name: First: Middle:			Birthdate: / /	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address:	City:	Zipcode:	Age:	Sex: ❑ M ❑ F
Email Address:	Home Phone:	Cell Phone:		
Occupation:	Employer:	Work Phone: ( )		
Address: City: State: Zip:				
Primary Physician: Phone:				
Whom may we thank for referring you to us? Phone:				

INSURANCE INFORMATION				
(Please give your insurance card and driver's license to the receptionist)				
Policy Holder (self, spouse, other):	Social Security #:			
Primary Insurance:	ID #:	Group #:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):	Policy Holder:	ID #:	Group #:	
Patient's relationship to policy :	❑ Self	❑ Spouse	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone: ( )	Other: ( )

The above information is true to the best of my knowledge. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered to me by Fit 4 Life Personal Training & Physical Therapy, Inc. I have read, understand and agree to all the information included in the new patient information packet. I have completed the above answers and I certify this information is true and correct to the best of my knowledge. I will notify Fit 4 Life of any changes in my health status or my personal information.

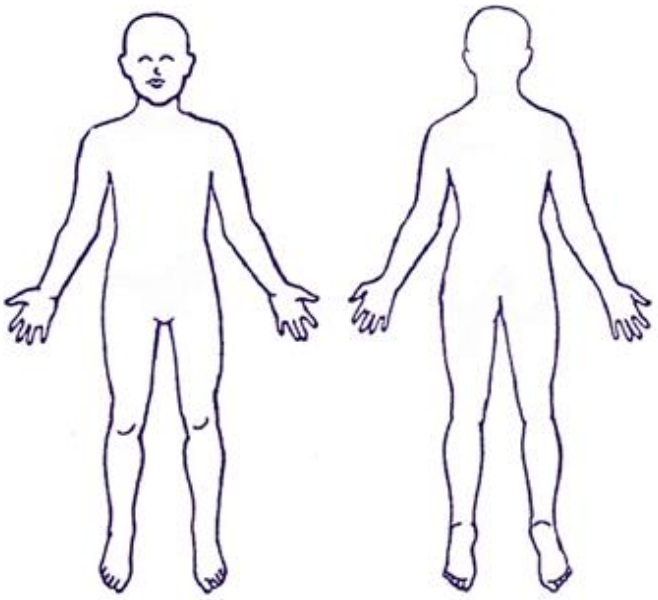
Patient/Guardian signature *Date*

Patient Medical History Form

Name_____ Today's Date_____
Age_____ Height_____ Weight_____ ☐ Right Handed ☐Left Handed
Occupation:_____
Are you currently off work because of this problem? ☐Yes ☐ No ☐ Light duty
Who referred you to this clinic? _____
What is your MAJOR complaint that you are seeking Physical Therapy Treatment for?_____
_____
When did your problems begin?_____
Was this problem due to: ☐ Injury ☐ Surgery ☐ MVA ☐ Other:_____

Rate your overall daily pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

Place an X or X's where your pain is located:



Describe your pain:
☐Dull ☐Ache ☐Shooting Pain
☐Sharp ☐Stabbing ☐Pins & Needles
☐Burning ☐Throbbing ☐Numbness/Tingling
☐Other_____

Is your pain constant? ☐Yes ☐No
Intermittent? ☐Yes ☐No
Fluctuates with activity? ☐Yes ☐No
Wakes you up at night? ☐Yes ☐No
Are you ever totally pain free? ☐Yes ☐No

What makes your symptoms worse?
☐ Sitting ☐ Standing ☐ Walking
☐ Lifting ☐ Bending ☐ Lying down
☐ Squatting ☐ Stress ☐ Other: _____

What makes your symptoms better?
☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying down ☐ Other: _____

Do you feel you symptoms are: ☐ Getting better ☐ Getting worse ☐Staying the same

Have you had this problem before? ☐Yes ☐No When? _____

Have you had any previous treatment for your current condition? ☐Yes ☐No
If yes, briefly explain: _____
_____

Have you had diagnostic studies for your current condition? ☐Yes ☐No
☐ X-ray ☐ MRI ☐ CT Scan ☐ Bone Density ☐ EMG ☐ Myelogram ☐Other:_____

Any previous injuries or surgeries whether orthopedic or not? ☐Yes ☐No
If yes, please explain:_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Any allergies that we should know about? ☐Yes ☐No _____

Please list **ALL** medications you are currently taking such as prescription and over-the-counter for this and any other condition: _____
_____
_____

Have you ever had a history of any of the following?

☐ Asthma/Respiratory Disorder
☐ Anemia
☐ Bowel/Bladder Changes
☐ Bruising Easily
☐ Balance Issues
☐ Bone Disease/Fractures
☐ Cancer
☐ Cardiac Disease
☐ Coordination Loss
☐ Chronic Headaches
☐ Current Pregnancy
☐ Diabetes
☐ Depression
☐ Dizziness
☐ Difficulty Walking
☐ Difficulty Swallowing
☐ Fever/Flu Recent
☐ Falls Recent/Frequent
☐ Glaucoma
☐ Hernia
☐ High Blood Pressure
☐ Heart Attack
☐ Hearing Problems
☐ Joint Replacement
☐ Numbness
☐ Nervous Disorder
☐ Osteoporosis
☐ Osteoarthritis
☐ Pacemaker
☐ Rheumatoid Arhtritis
☐ Stroke/CVA
☐ Seizures
☐ Smoking
☐ Shortness of Breath
☐ Severe Night Pains
☐ Sudden Weight Loss/Gain
☐ Vascular Disease
☐ Other:_____
_____

Does your current condition limit you in carrying out job duties? ☐ Yes ☐ No
Exlpain: _____
_____

Household duties? ☐ Yes ☐ No
Exlpain: _____
_____

What are your goals for physical therapy?_____
_____
_____

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

Signature: _____ Date: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices, and applicable law permits the terms of this notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Medical Information

Our commitment at Fit 4 Life Personal Training & Physical Therapy, Inc. is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates for treatment, payment and health care operations. For example:

- **Treatment**: We may use your medical information to treat you or disclose your medical information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your medical information to obtain payment for services we provide to you.
- **Health Care Operations:** We may use and disclose your medical information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certification, licensing or credentialing activities.
- **To You and on Your Authorizations:** You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.
- **To Your Family and Friends:** We must disclose your medical information to you, as described in the Individual Rights sections of this notice. We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.
- **Appointment Reminders:** We may use your medical information to contact you to provide you with appointment reminders.

- **Persons Involved in Care:** We may use or disclose medical information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your medical information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose protected health information based on a determination using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up forms of medical information.

- **Disaster Relief:** We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

- **Research:** We may use or disclose your medical information for research purposes in limited circumstances.

- **Death / Organ Donation:** We may disclose the medical information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

- **Required by Law:** We may use or disclose your medical information when we are required to do so by law. For example, we must disclose your medical information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your medical information when authorized by workers' compensation or similar laws. We may disclose your medical information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

- **Law Enforcement:** We may disclose your medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose your medical information to law enforcement officials. We may disclose limited information to law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the medical information of an inmate or other person.

- **Amendment:** You have the right to request that we amend your medical information. *(Your request must be in writing, and it must explain why the information should be amended.)* We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, or the amendment and to include the changes in any future disclosures of that information.

We at Fit 4 Life Personal Training & Physical Therapy, Inc. are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our office at 813-907-7879.

Notice of Receipt Acknowledgement

PURPOSE: This form is used to confirm that an individual has received the Fit 4 Life Personal Training & Physical Therapy, Inc. Notice of Privacy Practices.

I, _____, acknowledge that I have received Fit 4 Life Personal Training & Physical Therapy, Inc. **Notice of Privacy Practices.** I have had full opportunity to read and consider the content of this Notice of Privacy Practices.

Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____
Patient Name: _____ Social Security: _____
Address: _____ Phone Number: _____

Authorization for Release of Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing. This authorization is valid for a period of seven years. I understand that I am responsible for all professional services rendered for myself and/or my dependent. I also understand that payment is due at the time of service. When Fit 4 Life Personal Training & Physical Therapy, Inc. files insurance, I understand that it is my responsibility to assist in obtaining payment. I certify that information I have provided on this form is correct.

Signature: _____ Date: _____

Authorization and Release

Consent for Treatment:

I, the undersigned, hereby authorize Fit 4 Life Personal Training & Physical Therapy, Inc., the physical therapists assigned, and whomever he/she may designate as his/her assistant(s), to furnish the treatment ordered by my physician.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Fit 4 Life Personal Training & Physical Therapy, Inc., will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Fit 4 Life Personal Training & Physical Therapy, Inc. will be credited to my account upon receipt. I permit Fit 4 Life Personal Training & Physical Therapy, Inc. to endorse remittances for the conveyance of credit to my account.

However, I clearly understand and agree that all services provided are charged directly to me and that I am personally responsible for payment.

I, the undersigned, further agree that should interest be levied against this account in accordance with office policies, I will be responsible for that interest in the amount of 1% per month on the unpaid balance (equal to 12.68% per year). Should collection action in any form become necessary, the undersigned shall be responsible for all collection costs including but not limited to collection agency fees, attorney fees, and any court costs.

Patient's Signature: _____ Date: _____
Witness: _____

MedX Equipment Informed Consent

Our MedX program is a safe, reliable, and objective method of determining muscle strength and range of motion as well as a system of progressive resistance exercise rehabilitation. The MedX equipment is state-of-the-art and has been used in clinics worldwide since the late 1980's.

Certified personnel will carefully position you on the equipment. By stabilizing the torso using special restraints, specific musculature is properly isolated for testing. Prior to testing, you will be asked to perform dynamic exercise as a warm-up. The equipment does not force you to move in any way at any time; it responds to and accurately records your voluntary movements on a computer.

Test Procedure: First, your range of motion will be determined. Then, at several test angles within your range of motion, you will be asked to push against a cushioned pad, which will not move. You will hold each test position for four seconds, building up to maximal exertion by the fourth second. You will slowly relax your force and there will be a minimum of ten seconds rest between each exertion. It is advisable to take a deep breath prior to each

exertion, blowing it out as you build your force. Your evaluator will be looking for indications that you have given your best effort without causing any pain.

Exercise Procedure: If you elect the exercise rehabilitation program, you will be asked to perform short sessions of progressive resistance exercise. An individualized prescription will be developed to provide the best opportunity for you to improve your muscle strength and range of motion status. During these sessions, you will build force against the pad, which will move in response to you effort. The computer will record your movements.

Following any procedure, it is highly recommended that you use an ice pack for no more than 10 minutes at a time on the musculature tested or exercised. (Do not apply ice directly to the skin.) By using an ice pack within several hours of your procedure, you may prevent muscle soreness later. CAUTION: Never use a heating pad, as they can be very dangerous and are detrimental to the process of building your muscle strength. We also recommend that you drink plenty of water (preferably distilled water) after your test or exercise session.

Risk Involved: Although minimal, there are risks involved with these procedures. It is common to experience some initial muscle soreness, particularly after testing. It is normal for this soreness to last a day or two. If you have a prior injury, it is possible to experience a temporary pain increase. You should not jerk or push suddenly; you should move slowly and steadily. If you do experience pain at any time, you should stop pushing immediately and report it to your evaluator. You will never be asked to perform a procedure, which you do not feel you are able to perform.

Release, Indemnification and Hold Harmless. In consideration of being permitted to participate in the MedX testing and/or Exercise Rehabilitation Program, I agree release and waive an rights, claims or causes of action which I may have against Fit 4 Life Personal Training & Spine Strengthening LLC or its officers, directors, promoters, sponsors, employees and agents, which are related to, arise out of, or are in any way connected with my participation in the MedX testing and/or Exercise Rehabilitation Program, including specifically, but not limited to, the negligent acts or omissions of Fit 4 Life Personal Training & Spine Strengthening LLC for any and all injury, death, illness or disease, and damage to me or to my property, provided, however, that any act intended to due harm or act committed with willful of wanton disregard of my rights shall not be released. I further agree to hold Fit 4 Life Personal Training & Spine Strengthening LLC and its officers, directors, promoters, sponsors, employees and agents, harmless and to indemnify all such parties for, or on account of, any claims, suits or causes of action or injuries or death asserted by me or my family members, guests and invitees, or any of their heirs, assigns or successors.

Member's Warranty. You agree to participate on a voluntary basis, to the best of your ability. You also certify that you do not have a fresh fracture or have had recent abdominal surgery. To the best of your knowledge, you do not suffer from cardiopulmonary disease, osteoporosis, progressive neurological symptoms or signs, Cauda equine syndrome, aortic aneurysm, tumor, or other disability, impairment or ailment which would prevent you from engaging in, or would be detrimental to your health, safety, or physical condition if you do engage in, the MedX testing and/or Exercise Rehabilitation Program.

By signing this document, you acknowledge its receipt and certify that you understand the testing and rehabilitative exercise procedures, instructions, and risks.

I acknowledge that by signing this document I have given up certain legal rights and possible claims which I might otherwise assert or maintain against Fit 4 Life Personal Training & Spine Strengthening LLC, including specifically, but not limited to, rights arising from, or claims for, the negligent acts or omissions, in any degree, of Fit 4 Life Personal Training & Spine Strengthening LLC.

I acknowledge that by signing this document I have assumed responsibility and legal liability, including defense costs, for the claims or other legal demands, which may be asserted by other third parties against me as a result of my participation in this activity.

Date: _____
Participant Signature: _____
Participant Name: _____
Street Address: _____
City:_____ State:_____ Zip Code:_____

Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your payment responsibility.

Patients:

1. All patients must complete all new patient registration paperwork prior to seeing the Physical Therapist.
2. Full payment is due at the time of service: i.e., co-payments, deductible, and patient's co-insurance as determined by their insurance contract.
3. We accept cash, checks or credit cards as payment.
4. A $30 fee will be charged for any returned checks.
5. Adult patients are responsible for full payment at the time of service.
6. An adult must accompany minors receiving treatment at Fit 4 Life during all appointments. The adult accompanying a minor is responsible for full payment at the time of service.

Regarding Insurance:

If you have insurance, we will help you receive maximum benefits. We file claims to your insurance as a *COURTESY* to you. Any charge your insurance does not cover is *your* responsibility. By Law, your insurance company has 30 days to pay your charges.

If your insurance company has not paid the FULL BALANCE within 45 days, you will have 15 days to pay the balance. Fit 4 Life Personal Training & Physical Therapy, Inc. has the right to asses a daily interest charge at the most current applicable rate to unpaid accounts after 60 days from the date of service. If your insurance company pays more than the balance due, we will send you a refund check immediately.

Insurance is a contract between you and your insurance company. We are not a part to this contract in most cases. We will inform you if we are a party to your insurance contract. We will handle your claims according to our

agreement with the insurance company regarding deductibles, co-payments, and covered charges from secondary insurance. **Regardless of your insurance coverage, you are responsible for the timely payment of your account.**

Missed Appointments:

We require 24-hour advance notice to cancel or reschedule any appointments. ***Failure to provide 24-hour advanced notice will result in a late cancellation fee of $45.00 per missed appointment.***

Additionally, showing up for a scheduled appointment more than 15 minutes late will be considered a missed appointment and will be subject to the $45 late cancellation fee. Please help us to serve you and all our patients better by attending all scheduled appointments on a timely basis.

I have read, understand and agree to Fit 4 Life Personal Training & Physical Therapy, Inc. Financial Policy.
I authorize Fit 4 Life Personal Training & Physical Therapy, Inc. to deposit checks received on my behalf when made payable in my name.

Responsible Party Signature: _____ **Date**: _____

IMPORTANT NOTICE!!

NO SHOWS & LATE CANCELLATIONS (NOT 24 HOURS IN ADVANCE) ARE SUBJECT TO A

$45 FEE

X_____