FITSTAR
PHYSICAL THERAPY

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Fitstar Physical Therapy, LLC through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature_____ **Date**:_____ **Time:** _____
(Relationship to patient self—guardian—other:_____)

I further authorize Fitstar Physical Therapy, LLC to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____ **Date**:_____ **Time:** _____
(Relationship to patient: self - - guardian - - other:_____)

Authorization to Photograph: I grant permission to photograph the Patient for the purpose of patient identification.

Signature of Patient Or Legally Authorized Representative	Date	Time	Witness	Date	Time

FITSTAR PHYSICAL THERAPY

Patient Registration Form Today's Date:

Patient Information

First Name	MI	Last Name	Date of Birth	Age

Address	City	State	Zip

Please Check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address	Gender	Marital Status

Primary Care Physician	Referring Physician

Medicare Patients

Are you currently receiving any Home Health Services?	☐ Yes ☐ No	If "Yes" Please Describe Services

Employment Information

Employer	Job Title	Phone Number

Work Status	Student (Part-time or Full-time)

Emergency Contact Information

First Name	MI	Last Name	Date of Birth

Address	City	State	Zip

Please Check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

FITSTAR PHYSICAL THERAPY

PRE-EXAM QUESTIONNAIRE

Name:	
Reason For Coming To Therapy:	
Date of Injury:	Date of Surgery:

History of Present Condition:

Primary Concern/Chief Complaint:

PAIN	YES	NO
Do You Have Pain?		
Constant Pain?		
Night Pain?		
Numbness or Tingling;?		

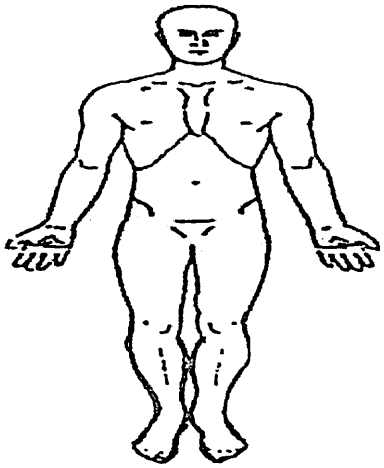
What activity increases your pain?

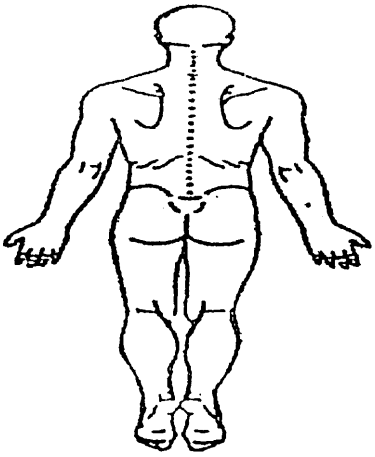
What eases your symptoms?

PLEASE RATE YOUR PAIN ON A SCALE:
0----1-----2-----3-----4-----5-----6----- 7-----8-----9-----10
NO PAIN WORST POSSIBLE PAIN

At Worst Time: _____
Currently: _____
At Best Time: _____

Please mark on the drawing where your pain is located:





PAST MEDICAL HISTORY

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes			Kidney Problems			Thyroid Problems		
Arthritis			Pregnant			CVA/Stroke		
High Blood Pressure			Allergies			Previous Fracture		
Heart Disease			Seizures			Osteoporosis		
Pacemaker or Surgical			Metal in Body			Respiratory Problems		
Headaches			Cancer/Tumor			Other:		

Any special tests completed for this injury? If so, please list the results:

MRI:	X-RAY:	CT SCAN:	EMG:

MEDICATIONS:

Prescription/Over-the-Counter Vitamins	Frequency	Dosage

Patient/Guardian Signature: _____

FITSTAR PHYSICAL THERAPY

Important Company Policies

We strive to provide you the best personalized care available. To make this possible, we adhere to a set of very important guidelines. Please read them carefully and indicate your agreement by signing your initials in the boxes provided next to each policy.

☐ **COPAYS ARE DUE UPON ARRIVAL**
If you happen to forget your wallet or checkbook, we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **NO-SHOWS ARE BAD**
If you fail to show for **three consecutive appointments** without notice, all future appointment will be removed and a **$50 fee** assessed to your account. You may reschedule appointments again on a "first come, first serve basis".

☐ **IMPORTANT NOTICE FROM THE FEDERAL GOVERNMENT**
"It is unlawful to routinely avoid paying your copay, deductible, or coinsurance payments…even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outline in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's – Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

We look forward to building a relationship with you that will last a lifetime!

Financial Policy and Patient Responsibility

Fitstar Physical Therapy is committed to providing our patients with the highest quality care. We thank you for taking the time to read and understand our policy.

It is the Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan and covered, non- covered benefits, authorization requirements, and cost share information such as deductibles, coinsurances, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primacy Care Provider (PCP) and/or obtain authorization from treatment from their insurance carrier prior to receiving services.
- Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment or deductible at the time of service.
- To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claim payments by contacting their insurance carrier when needed.

It is Fitstar Physical Therapy's responsibility:

- To provide quality medical care
- To file insurance claims as a courtesy to the patient. A 60 day period will be extended for pending insurance payments, after which, the patient may be held responsible for the balance.

Medicare Patients Acknowledgement

I understand that this Fitstar Physical Therapy, LLC facility is a provider-based location based in Dallas. The actual liability will depend on the actual services delivered. The estimated charges for visits to the facility are: $275.00 - $400.00._Please note that your final costs may be higher or lower, as this is only an estimate.

_____ _____

Patient or Responsible Party Signature Date

Financial Policy Acknowledgement

I have read and understand the above financial policy. I understand that regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

_____ _____

Patient or Responsible Party Signature Date

Release of Medical Information and Assignment of Benefits

I authorize the release of medical information necessary for filling health insurance claims for me by Fitstar Physical Therapy, LLC. I also authorize my insurance carrier(s) to make payment directly to Fitstar Physical Therapy, LLC.

_____ _____

Patient or Responsible Party Signature Date

How Did You Hear About Us?

Please take a moment to circle the applicable answers below

First and Last Name: _____

Date of Appointment: _____

Time of Appointment: _____

Did you find us on the internet?

- Google Ad/Google Search
- Social Media (Facebook, Twitter, Linked-In)
- Other (please specify):

_____

Did your doctor refer you specifically to Fitstar Physical Therapy? If so, what is the name of your doctor?

Did your find us through your insurance provider?

Did you hear about us through a friend or family member? If so, who?

_____

FITSTAR PHYSICAL THERAPY

17400 Dallas Parkway, Suite 210
Dallas, TX 75287

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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.

If you have any questions about this notice, please contact Danaree Allgood at 469-372-5399 or danaree@fitstarpt.com .

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from [Covered Entity Name]. Your health information may include information created and received by [Covered Entity Name], may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart

continued

condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our organization may share information about you and disclose information to people who do not work for [Covered Entity Name] in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

• **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at [Covered Entity Name] may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

• **For Health Care Operations.** We may use and disclose health information about you in order to run [Covered Entity Name] and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

• **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

• **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

• **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

• **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

• **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

• **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

• **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

• **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

• **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar

process, subject to all applicable legal requirements.

• **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

• **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

• **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. Examples of disclosures requiring your authorization include disclosures to your partner, your spouse, your children and your legal counsel.

We also will not use or disclose your health information for the following purposes without your specific, written Authorization:

[Include the following if applicable]

• ***For our marketing purposes.*** *This does not including face-to-face communication about products or services that may be of benefit to you and about prescriptions you have already been prescribed.*

• ***For the purpose of selling your health information.*** *We may receive payment for sharing your information for, as an example, public health purposes, research, and releases to you or others you authorize a release to as long as payment is reasonable and related to the cost of providing your health information.*

• ***Any disclosure of your psychotherapy notes.*** *These are the notes that your behavioral health provider maintains that record your appointments with your provider and are not stored with your medical record.*

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing,** at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as psychotherapy notes, HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

• **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to *[designated privacy official/contact person]* in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit

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your request in writing to *[designated privacy official/contact person]*. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

• **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by *[Covered Entity Name]*.

To request an amendment, complete and submit a medical record amendment/correction form to *[designated privacy official/contact]*.

We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be *(number)* of pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

• **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request in writing to Danaree Allgood at Fitstar Physical Therapy, LLC, 17400 Dallas Tollway, Suite 210, Dallas, TX 75287 *[designated privacy official/contact person]*. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

We are required to agree to your request *if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes.*

There may be instances where we are required to release this information if required by law.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to *[designated privacy official/contact person].*

• **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request for Restriction On Use/Disclosure Of Medical Information and/or Confidential Communication to *[designated privacy official/contact]*. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

• **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice.

You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. *[You may also find a copy of this Notice on our web site.]*

To obtain such a copy, contact Danaree Allgood at (xxx) xxx-xxxx or danaree@fitstarpt.com.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. {*If a direct care provider* - We will post the current notice at our location(s) with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region [*Region Covered Entity is located* in] U.S. Department of Health & Human Services *[Address, phone number and other related contact information for the OCR office in the region the Covered Entity is located in]*

To file a complaint with [*Covered Entity name*], contact [*insert the name, title, and phone number of the contact person or office responsible for handling complaints listed on the first page as the contact for more information about this notice.*]. ***You will not be penalized for filing a complaint.***