Patient's Name (Last) _____ (First) _____ (MI) _____

Address_____
Street City State/Zip

Phone Number _____
Home Cell Work Other

Patient Social Security Number _____ Gender ___Male ___Female

Patient Date of Birth _____/_____/_____ Patient Email Address _____

Marital Status __ Married __ Single __ Divorced __ Widowed __ Minor

Spouse Name _____ Spouse DOB ___/___/___

Emergency Contact Name _____ Phone Number _____

Employment Status __Employed __Student __Retired __Unemployed

Employer_____ Spouse's Employer _____

Are you a current member of Total Fitness Connection? YES / NO

How did you hear of us? _____
(Example: Your doctor, Friend, Internet, Billboard, Radio, TV, etc.)

Have you received Home Health Care within the last 12 months? ____
If so, when was your last visit?_____ What agency provided your Home Health care?_____

Have you had physical therapy or chiropractic visits this year? _____
If yes, how many? _____ Where did you receive this care? _____

Responsible Party Information - (Leave blank if the same as above)

Responsible Party Name

(Last) _____ (First) _____ (MI)_____

Address_____
Street City State/Zip

Phone Number _____
Home Cell Work

Social Security Number _____ Gender __Male __Female

Date of Birth ____/____/____ Driver's License# _____

Email Address _____ Relationship to the patient? _____

Employment Status __ Employed __ Student __ Retired __ Unemployed

Employer _____

WORKERS COMP CLAIMS AND AUTO ACCIDENT ONLY

What is the date of the accident? _____

Was this a ____Work-related injury or _____Motor Vehicle Injury?

What State did the accident occur? _____

Have you obtained the services of an attorney? __Yes ___No

If yes, please provide us with the name, address, and phone number of this attorney:

Name _____

Address _____

Phone _____

Do you give TFC Physical Therapy permission to release your medical records to this attorney?
____Yes ____ No

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Guardian if Minor **Relationship to Patient**

Acknowledgement of Receipt Notice Of Privacy Practices

I, _____, have received the Notice of Privacy
(Print Patient Name)

Practices from TFC Physical Therapy, PLLC.

X_____ Date: _____
Patient Signature

In lieu of patient signature, I, _____, a staff member
(Print TFC Employee Name)

of TFC Physical Therapy, PLLC, state that _____
(Print Patient Name)

has been given our current Notice of Privacy Practices.

X_____ Date: _____
TFC Employee Signature

Consent and Release

I, the undersigned, assign directly to Total Fitness Connection, PLLC all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** I agree to pay all cost of collection including attorney fees, collection fees and contingent fees to collection agencies of not less than 40%, such contingency fee to be added and collected by the collection agency immediately upon my default and referral of my account to said collection agency. I hereby authorize Total Fitness Connection, PLLC to release all information necessary to secure the payment of benefits. I authorize use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent/Guardian if Patient is a Minor **Date**

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Total Fitness Connection, PLLC for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**

Total Fitness Connection

Outcome Assessment

This questionnaire will help your therapist and this clinic determine the effectiveness of specific treatments. This will allow us to optimize our rehabilitation services to you and other patients. Your responses will be kept confidential. Thank you for your assistance.

INSTRUCTIONS: Please rate your current limitations as they relate to the following by filling in the circle to which your condition applies. **None:** No difficulty **Mild:** least difficult to perform. **Moderate:** somewhat difficult to perform. **Max:** very difficult to perform. **Unable**: unable to perform activity.

Today's Date: _____

	No Difficulty	Mild Difficulty	Moderate Difficulty	Maximum Difficulty	Unable
Daily Activities: (Example= dressing, bathing, eating, traveling)	○	○	○	○	○
Work Activities: (Example= job duties, yard work, housekeeping)	○	○	○	○	○
Recreation/Sport Activities: (Example= walking, swimming, biking)	○	○	○	○	○
Movement: (Example= getting into desired positions, range of motion)	○	○	○	○	○
Pain/Symptoms: (Example=discomfort, numbness, swelling)	○	○	○	○	○

***Your goal for physical therapy*:**

_____

_____

_____

Total Fitness Connection Physical Therapy Medical History Form

Name_____ Age_____ Height_____ Weight_____
Referring Physician:_____ Family Physician:_____
Reason for today's visit:_____
When did it start?_____

Please mark any of the following that apply to your current or past medical status:

___ abnormal fatigue
___ abnormal weakness
___ anxiety / depression
___ asthma
___ broken bone
___ bronchitis/emphysema
___ cancer
___ family member with cancer
___ cold allergy
___ Diabetes type I / II
___ difficult or frequent/urgent urination
___ dizziness / lightheadedness
___ epilepsy / seizures
___ fever / chills / sweating
___ heart attack
___ heart murmur
___ hypertension (high blood pressure)
___ latex allergy
___ mental illness
___ multiple sclerosis
___ nausea / vomiting
___ night sweats
___ numbness or tingling
___ osteoarthritis
___ rapid heart rate or racing heart beat
___ recent illness or hospitalization
___ recent weight gain or loss
___ rheumatoid arthritis
___ severe or unrelenting headaches
___ shortness of breath
___ stroke
___ uncontrollable bladder or bowels

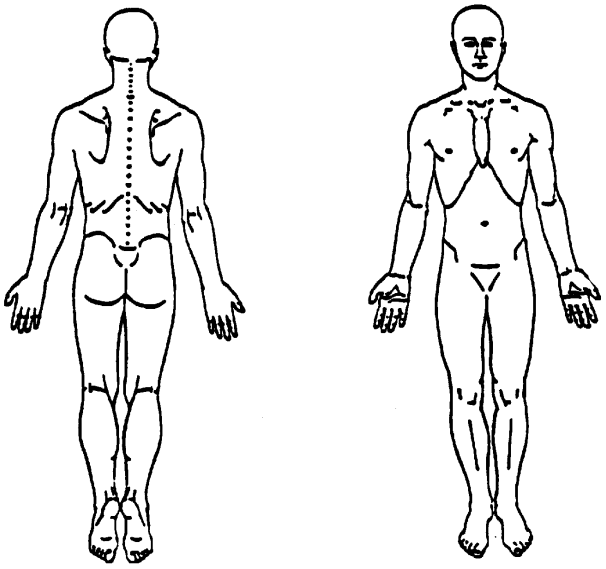
Please explain any items marked above: _____
_____

Please list any medications you are currently taking:_____
_____

Please list any previous surgical procedures:_____
_____

Do you currently smoke? Yes / No If a previous smoker, when did you quit smoking? _____
Do you consume alcohol? Yes / No How many drinks per week? _____
Do you consume caffeine? Yes / No How many drinks per day? _____
At the present time, do you consider your health to be **excellent**, **good**, **fair**, or **poor**? (circle one)
Are you currently under the care of a physician? Yes / No
If yes, please explain:_____
_____

Indicate on the diagram where your pain is located and what type of pain you feel at the present time. Do not indicate areas of pain that are not related to your present injury or condition. Use the symbols provided to describe your pain.



KEY
///// Stabbing
XXX Burning
0000 Pins and Needles
==== Numbness
VVV Aching

X_____
Physical Therapist Signature
(PT has read and reviewed the patient's medical history)

TFC PHYSICAL THERAPY
CANCELLATION POLICY

We would like to take this opportunity to welcome you to Total Fitness Connection Physical Therapy. Our commitment to our patients takes priority. Because of this commitment to each patient, we ask that all patients be courteous and provide us with a 24-hour notice prior to canceling your appointment with us. We understand that plans get changed, sometimes suddenly. But whenever possible, we ask that you provide us with at least 24 hours so that we may give your time slot to another deserving patient. A cancellation fee of $25.00 will apply to each appointment that was cancelled without a 24-hour notice. Thank you for your cooperation.

TFC PHYSICAL THERAPY
FINANCIAL POLICY

A. Copy of insurance card and a photo I.D. are requested at the time of initial visit.

B. Payment of co-insurance and /or deductible is due at time of service.

C. This office accepts Visa, MasterCard, Discover, American Express, and Debit Cards.

D. This office accepts checks with proper I.D. A $15.00 charge will be assessed for returned checks.

E. We will file supplemental insurances when appropriate.

F. Payment arrangements can be made at time of service.

G. Balance bill payment due within 30 days of final payment by insurance company.

H. If you do not have insurance, total payment is due at time of service, unless payment arrangements have been authorized.

X_____ Date: _____

Patient Signature

NOTICE OF PRIVACY PRACTICES FOR TOTAL FITNESS CONNECTION PHYSICAL THERAPY

THIS NOTICE DESCRIBES HOW HEALTH 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 Shelia Moutardier, Privacy Official at (270)781-1151. This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

Our Pledge Regarding Health Information

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

Make sure that health information that identifies you is kept private; Give you this notice of our legal duties and privacy practices with respect to health information about you; and Follow the terms of the notice that is currently in effect.

How We May Use and Disclose Health Information About You
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation or for other treatment purposes. For example, a physical therapist is treating a patient following a myocardial infarction and discovers that he is uninformed about proper diet. She refers the patient to a dietitian and may need to tell the dietitian about the status of physical therapy treatment. Or, a pediatrician refers a child to a physical therapist for examination/evaluation. The physical therapist discovers that the child is not performing with age-appropriate motor skills and has noted impairments. The physical therapist refers the child to the state's Early Intervention Official for early intervention services and may need to give the EIO information from the child's evaluation. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. 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 cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

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

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. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

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 activities. These activities generally include the following: To prevent or control disease, injury or disability; To report births and deaths; To report child abuse or neglect; To report reactions to medications or problems with products; To notify people of recalls of products they may be using; To notify person or organization required to receive information on FDA-regulated products; To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits,
investigations, inspections, and licensure.

These activities are necessary for the government 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. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:
In reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime; In response to a court order, subpoena, warrant, summons or similar process; To identify or locate a suspect, fugitive, material witness, or missing person: -Name and address -Date of birth or place of birth -social security number -blood type or rh factor -type of injury -date and time of treatment and/or death, if applicable -a description of distinguishing physical characteristics; About the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement; About a death we believe may be the result of criminal conduct; About criminal conduct at our facility; and In emergency circumstances to report crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.
National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect you health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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 health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit you request in writing to Shelia Moutardier, Privacy Official. If you request a copy of the information, we may charge a fee

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 health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Shelia Moutardier, Privacy Official, at (270) 781-1151. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that 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 for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to Shelia Moutardier, Privacy Official, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, unless the person of entity that created the information is no longer available to make the amendment; Is not part of the health information kept by or for our practice; Is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to Shelia Moutardier, Privacy Official. Your request must state a time period which many not be longer than six years and may not include dates before March 1, 2004. 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. We will mail you a list of disclosures in paper form within 30 days of you request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

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 your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Shelia Moutardier, Privacy Official. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to you spouse.

Right to Request Confidential Communications: Your have the right to request that we communicate with you about health 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 a post office box.

To request confidential communications, you must make your request in writing to Shelia Moutardier, Privacy Official. 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 obtain a paper copy of this notice at any time. However, at the time of first service rendered after March 1, 2004, it is required that you receive a paper copy. To obtain a copy, please request it from Shelia Moutardier, Privacy Official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Shelia Moutardier, Privacy Official. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use of disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.

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