Vitality SarcoHealth™ Clinics

## ASSIGNMENT OF BENEFITS AND FINANCIAL POLICIES

**Consent to Release / Obtain Medical Information:** I authorize Vitality SarcoHealth to release my information to my insurance company as necessary to verify any benefits to which I am entitled and as necessary for Vitality SarcoHealth to be reimbursed for the services it provides to me.

**Assignment of Benefits:** I assign to Vitality SarcoHealth all rights, benefits, insurance and insurance reimbursements to which I may be entitled for any services provided by to me by Vitality SarcoHealth, regardless of its managed care network participation status. I request that payment of authorized insurance benefits be made to Vitality SarcoHealth on my behalf. I designate Vitality SarcoHealth as my representative in dealings with third-party payors related to the services it provided to me and authorize Vitality SarcoHealth to receive information about me as well as file complaints and appeals on my behalf.

**Workers Compensation:** I understand that if I claim Workers' Compensation benefits and charges for services rendered to me are denied, I may be responsible for the charges for services.

**Returned Checks:** Checks returned due to insufficient funds may be subject to a $25 processing fee.

**Financial Policy: I understand that Vitality SarcoHealth is out-of-network with most insurance carriers.** I understand that Vitality SarcoHealth will bill my insurance carrier as a courtesy to me. I will be responsible for all copays/co-insurance and deductibles that may apply. I agree that I am also responsible for any charges that are not paid by my insurance carrier and/or are not paid by my insurance carrier within 60 days. If my health benefits plan changes while undergoing treatment with Vitality SarcoHealth, I am required to notify Vitality SarcoHealth of this change. In the event that my insurance carrier requests a refund of any payments made to Vitality SarcoHealth (e.g., my carrier pays the claim for services but later determines that the services are not a benefit under my health plan), I may be responsible for the service charges. If my insurance carrier sends any payment directly to me for services billed by Vitality SarcoHealth, I will promptly remit the payment(s) to Vitality SarcoHealth. If formal collections procedures become necessary I agree that I will be responsible for additional costs incurred by Vitality SarcoHealth for such collection costs.

Below is a good faith estimate of my health benefits to help me understand what services are covered / not covered by my benefits plan as well as any co-payments or deductibles for which I am responsible. I understand that this information is based on an initial verification of benefits with my insurance carrier, however, there is no guaranty that my carrier will pay the claim for services once submitted. I understand that this is an estimate and may vary if, for example, additional services are provided or my health benefits plan changes. **The below information was explained to me and I understand my responsibility for payment.**

**Benefits Analysis and Estimate:**

Estimated Annual Deductible: Co-Pay: $ _____ / visit Visit Limit: _____

$ _____ / year Co-Insurance $ _____ / visit

Payment Agreement: $_____ due from client each visit

Notes:_____

_____

_____ _____

Completed By Date

**For added convenience of re-occurring co-pays and co-insurance, we provide automatic transactions through our Patient EHR and Billing System on the credit card you authorize.*

_____ _____ _____

Client Signature Print Name Date

_____ _____ _____

Vitality SarcoHealth Witness Signature Print Name Date

Vitality SarcoHealth™ Clinics

**NOTICE OF PRIVACY PRACTICES &**
**ACKNOWLEDGMENT OF RECEIPT**

*BELOW IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION. READ IT CAREFULLY.*

## How Vitality Health May Use and Disclose Your PHI

- ActiveRx Inc. dba Vitality SarcoHealth ("Vitality SarcoHealth") is required by law to keep your health information confidential and to inform you of how your information may be used or disclosed.
- Vitality SarcoHealth may use and disclose your protected health information (PHI) to carry out treatment (e.g., coordination of care with your physician), payment (e.g., submitting your PHI to your health benefits plan for reimbursement purposes), and other healthcare operations (e.g., to evaluate staff and quality of care) and is permitted to do so without obtaining your authorization.
- Vitality SarcoHealth may also use or disclosure your PHI as required for public health activities, to report child abuse or neglect, for investigations or oversight activities, in certain judicial proceedings (e.g., a court order), for law enforcement purposes, to coroners and examiners to identify a deceased person or cause of death, and other purposes delineated by applicable law additional examples are included in the Notice of Privacy Practices (NPP)).
- Most other uses and disclosures require your authorization.
- When you provide Vitality SarcoHealth with an authorization to disclose your PHI, you can revoke the authorization at any time.

**Please see Vitality SarcoHealth's NPP for a more complete description**.

## Summary of Your Rights

- You have the right to access and receive a copy of your treatment record and to receive a timely response to your request.
- You have the right to request that Vitality SarcoHealth restrict how it uses and discloses your PHI though Vitality SarcoHealth is not required to agree with the requested restriction.
- You have the right to receive confidential communications.
- You have a right to request an amendment to your PHI.
- You have the right to be notified if there is a breach involving your PHI.
- You have the right to receive an accounting of how your PHI has been used and disclosed.

**Please see Vitality SarcoHealth's NPP for a complete description of your rights.**

Should you have any concerns about the use or disclosure of your PHI or you have a compliant regarding any violation of your privacy rights you may contact the Vitality SarcoHealth Privacy Officer as detailed in the NPP. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Vitality Health will not retaliate against you for filing a complaint.

**A copy of Vitality Health's Notice of Privacy Practices was made available to me. I also understand that I may obtain the Notice of Privacy Practices at any time by visiting choosehowyouage.com/privacy or requesting a copy at any of the Vitality SarcoHealth facilities.**

| Client Signature | Print Name | Date |
|---|---|---|

Vitality SarcoHealth™ Clinics

**COMMUNICATION PREFERENCES**

1. May we phone, email, or send a text to you to confirm appointments?

   Email: ___ YES ____ NO If yes, provide preferred email address:_____

   Text: ___ YES ____ NO If yes, provide preferred phone number: _____

   Telephone: ___ YES ____ NO If yes, provide preferred phone number: _____

   Note: your mobile carrier may apply data charges for text messages.

2. May we leave a message on your answering machine or voicemail at home or on your cell phone?

   Home: ____ YES ____ NO

   Cell: ____ YES ____ NO

3. May we send you communications other than appointment reminders via email?
   ___ YES ____ NO

4. If you wish to allow Vitality SarcoHealth to discuss your medical condition or treatment with a friend, family member or other individual please indicate such individual(s) below:

| Name | Relationship to Client | Phone Number |
|---|---|---|
| Name | Relationship to Client | Phone Number |

Vitality SarcoHealth™ Clinics

**INFORMED CONSENT**

I seek the services of ActiveRx Inc. dba Vitality SarcoHealth and its representatives ("Vitality SarcoHealth"). I am executing this consent to confirm my discussion with Vitality SarcoHealth and understanding of the risks, benefits, and alternatives to treatment by Vitality SarcoHealth.

**1. Benefits of Treatment with Vitality SarcoHealth**

I understand that services and treatments offered by Vitality SarcoHealth are intended to help me recover, maintain, and enhance my ability to live an active and independent lifestyle.

**2. Risks**

I understand that the treatment, modalities, and equipment employed by Vitality SarcoHealth may carry certain risks. I understand that the physical response to a specific treatment can vary widely from person to person, and that it is not always possible to predict an individual's response to a given modality or procedure. I understand that the services I receive from Vitality SarcoHealth may cause discomfort, pain, or injury, or may aggravate a previously existing condition. I understand that if I have any questions or concerns about the services, I receive from Vitality SarcoHealth, I should raise these with my physical therapist or another Vitality SarcoHealth representative.

**3. Alternatives**

I understand that my health care provider may recommend alternatives to services from Vitality SarcoHealth to help me meet my health goals, and that if desired, I should ask my health care provider for more information.

**4. Representations**

I understand that Vitality SarcoHealth makes no representations, guarantees or warranties that my medical or health problems or conditions or injuries will improve by undergoing treatment or services with Vitality SarcoHealth. I understand that my failure to comply with treatment recommendations may impede results.

I am responsible to disclose to Vitality SarcoHealth all medications, care, and assessments that I receive elsewhere and to provide medical records as needed from other providers to ensure that care is coordinated and appropriate for my condition. If my health or physical condition changes, I will alert Vitality SarcoHealth.

I understand that Vitality SarcoHealth will perform a physical evaluation, provide physical therapy and/or strength therapy® and assist with exercises and other related services. I understand that these activities/services may involve bodily contact including, without limitation, touching and direct contact. With my signature below, I agree to such contact and agree to inform Vitality SarcoHealth if any contact makes me feel uncomfortable.

**5. Consent to Release/Obtain Medical Information:** I authorize Vitality SarcoHealth to release my medical information to physicians/facilities who have a treatment relationship with me as necessary for further treatment or to coordinate care. Permission is hereby granted to any physician with whom I have a treatment relationship and facility where I was previously treated to release my medical records to Vitality SarcoHealth.

**I certify that I have read this Informed Consent and understand the risks, benefits and alternatives to the services recommended for me. I had the opportunity to raise questions regarding this Informed Consent I received satisfactory answers to my questions. I hereby agree to and accept all of the terms above.**

| Client Signature | Print Name | Date |
|---|---|---|

For Office Use Only: *I informed the client of the available alternatives and of the potential risks. To the best of my knowledge, the client has been adequately informed, had his/her questions answered and has consented.*

| Vitality SarcoHealth Rep Signature | Print Name | Date |
|---|---|---|

Vitality SarcoHealth™ Clinics

**MISSED APPOINTMENT & CANCELLATION GUIDELINES**

At Vitality SarcoHealth, our mission is to *redefine aging and the way you think about aging*. We are different from the other rehab, physical therapy, and medical facilities you may have visited in the past—our services involve proven strength and muscle regeneration protocols provided by highly specialized sarco-physical therapists in a personalized, typically one-on-one manner that often produce life-changing improvements. Our desire is for you to find great value and benefit in the experience we deliver.

We understand that life happens. Last minute travel plans, family in town, car problems, physician appointments and illness are just a few of the reasons why you may need to change or cancel your appointment. At the same time, because we are the only SarcoHealth clinic in this community and the needs are so vast we often have a waiting list of people who are eager to get in; so, we would very much appreciate as much advance notice as possible to give us sufficient time to fill your spot when you can't make it in.

Since insurance companies do not allow health care companies to bill for missed appointments (or appointments that we are unable to fill) and we need to ensure our providers are compensated consistently, we charge a $40 fee for all appointments that are cancelled with less than 24-hours' notice. **However, when you are able to reschedule your appointment within the same week, we waive this fee.**

Please sign below to acknowledge that you have read, understand and agree to our Missed Appointment & Cancellation Guidelines. By doing so, you are authorizing us to charge the credit card you place on file $40.00 each time you cancel an appointment without at least 24-hours' notice.

| Client Signature | Print Name | Date |
|---|---|---|
| Vitality SarcoHealth Witness Signature | Print Name | Date |

Vitality SarcoHealth™ Clinics

## CREDIT CARD AUTHORIZATION

As you know, when you check into a hotel or rent a car, the first thing you are asked to provide is a credit card, which is swiped and later used to pay your bill. This is an advantage for both you and for the hotel or rental company, since it makes checkout easier, faster and more efficient.

Vitality SarcoHealth does something similar. We ask for a credit card number at your initial appointment and the information will be held encrypted until your health benefits plan(s) has paid its portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card. Co-pays due at the time of visit will, of course, still be due at the time of the visit.

This will be an advantage to you, since you will not have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out each month. The combination will benefit everyone in helping to keep the cost of healthcare down.

***This credit card policy in no way will compromise your ability to dispute a charge or to question your insurance company's determination of payment.*** No employees of Vitality SarcoHealth will have access to your stored credit card information. And you may change the credit card on file at any time.

**With your signature below, you authorize Vitality SarcoHealth to charge co-pays, coinsurance, and outstanding balances to the credit card provided to Vitality SarcoHealth.**

| Client Signature | Print Name | Date |
|---|---|---|

Vitality SarcoHealth™ Clinics

## ENROLLMENT INFORMATION

| | | | |
|---|---|---|---|
| First Name | Last Name | | M.I. |
| Address | City | State | Zip |
| DOB / / Age | ___ Male ___ Female | | |
| Home Phone # | Cell phone # | | |
| Email | | | |
| How Did You Hear About Us? | | | |

## EMERGENCY CONTACT INFORMATION

| | |
|---|---|
| Name | Relationship |
| Home Phone # | Cell Number # |

## PROVIDER CARE INFORMATION

| | | |
|---|---|---|
| Referring Physician | Referring Physician Phone # | |
| Reason for Referral | | |
| Injuries | Surgery ___ Yes ___ No | Date: / / |

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Name Primary Insurance | Insurance Phone # | | |
| Subscriber's Name | DOB: / / | | |
| ID # | Group # | | |
| Relationship to Patient ___ Self ___ Spouse ___ Child ___ Other | | | |
| Name of Secondary Insurance | | | |
| Subscriber's Name | DOB: / / | | |
| ID # | Group # | Relationship: ___ Self ___ Spouse ___ Other | |

## MISCELLANEOUS INFORMATION

| | | |
|---|---|---|
| Is it ok to leave a message at the phone number provided above? | ___Yes | ___ No |
| Would you like to receive text appointment reminders? | ___Yes | ___ No |
| Are you currently receiving in-home or outpatient Physical Therapy services? | ___Yes | ___ No |
| Have you received in-home or outpatient Physical Therapy services in the past 12 months? | ___Yes | ___ No |
| ****If yes to either question above, please notify your patient care coordinator as this may affect your insurance coverage**** | | |
| Do you have a Pacemaker? | ___Yes | ___ No |

**I certify that all of the information above is, to the best of my knowledge, true, correct and complete.**

_____ _____

Client Signature Date

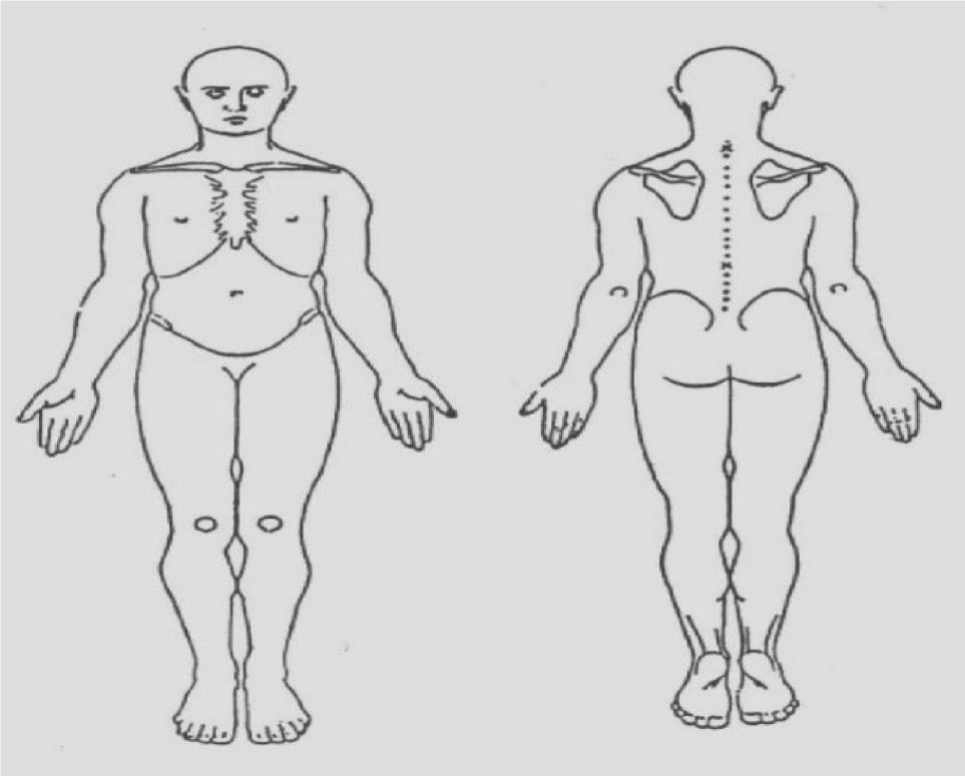
*For office use only:*

Service Scheduled: ____ **ST/PT** ____ **SE/IE** ____**SHS** on ____ /____ @ _____:_____ with:_____

Vitality SarcoHealth™ Clinics

Client Name: _____ Date: _____

Present Condition: Pain / Tension _____



**Please place an "X" in the area or areas where you are experiencing pain / symptoms.**

Use the descriptions of pain below to indicate the type of pain you feel. Draw an arrow from the "X" to each specific type of pain below.

- **SEVERE**
- **DULL**
- **STABBING**
- **MODERATE BURNING**
- **NUMBNESS / TINGLING**
- **THROBBING**
- **WEAKNESS**
- **SHARP**
- **RADIATING**

Please list each symptom that you are experiencing and rate each on a scale of 0 – 10. *(0 = no pain 10 = severe pain).*

| ***Symptoms*** | ***Rate Severity*** |
|---|---|
| _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| _____ | 0 1 2 3 4 5 6 7 8 9 10 |

What makes your symptoms worse? ___ Sitting ___ Standing ___ Lifting ___ Bending ___ Other

Date of injury/symptom onset _____ What initially caused your pain? _____

Have you had a related surgery? ___ Yes ___ No If yes, what was the date? _____

Has the pain changed since onset? ___ Yes ___ No

Have your symptoms become: ___ Better ___ Worse ___ Same

How often do you experience the pain? ___ Ongoing ___ Intermittently ___ On Occasion

Other _____

Are you taking any medication? ___Yes ___ No

If yes, please provide a list of medications or list medications here: _____

_____

_____

Vitality SarcoHealth™ Clinics

**MEDICAL HISTORY**: Please check any that apply to you historically or currently.

### HEART/BLOOD VESSELS

- ○ **NONE**
- ○ Heart Failure
- ○ TIA
- ○ Peripheral Arterial Disease
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Heart Attack
- ○ Poor Circulation
- ○ Stroke
- ○ Pacemaker
- ○ High Cholesterol
- ○ Aortic Stenosis
- ○ Abdominal Aortic Aneurysm
- ○ Irregular Heart Beat
- ○ DVTs
- ○ Edema
- ○ Other: _____

### BRAIN & NERVES

- ○ **NONE**
- ○ Headaches/Migraine
- ○ Neuropathy
- ○ Parkinson's
- ○ Dementia/Alzheimer's
- ○ Seizures
- ○ Meningitis
- ○ Multiple Sclerosis
- ○ Chronic Fatigue Syndrome
- ○ Vision
- ○ Tingling in Arms/ Hands/Feet
- ○ Nervousness
- ○ Difficulty Sleeping
- ○ Other: _____

### JOINT/SKELETON/ MUSCLE

**NONE**

- ○ Joint Pain
- ○ Surgery:

___ Knee ___ Hip
___ Shoulder ___ Back
___ Ankle ___ Neck

- ○ Osteoporosis
- ○ Fractures
- ○ Osteoarthritis
- ○ Gout
- ○ Scoliosis
- ○ Metal Implants
- ○ Fibromyalgia
- ○ Rheumatoid Arthritis
- ○ Other: _____

### LUNGS

- ○ **NONE**
- ○ Emphysema
- ○ COPD
- ○ Smoker
- ○ Asthma
- ○ Shortness of Breath
- ○ Hay Fever
- ○ Chronic Bronchitis
- ○ Tuberculosis
- ○ Asbestosis
- ○ Pneumonia
- ○ Pulmonary Embolism
- ○ Sleep Apnea
- ○ Lung Cancer
- ○ Home Oxygen
- ○ Other: _____

### KIDNEY/BLADDER/LIVER

- ○ **NONE**
- ○ Stones
- ○ Kidney Failure/ Dialysis
- ○ Bowel/Bladder Issue
- ○ Urinary Tract Infection
- ○ Hepatitis A B C D
- ○ Cirrhosis
- ○ Other: _____

### BLOOD DISORDERS

- ○ **NONE**
- ○ Anemia
- ○ Sickle Cell Anemia
- ○ Bleeding Disorder
- ○ History of Blood Transfusions
- ○ Clot
- ○ Myelodysplastic Disorder
- ○ Other: _____

### SKIN DISORDERS

- ○ **NONE**
- ○ Acne
- ○ Eczema
- ○ Psoriasis
- ○ Warts
- ○ Shingles
- ○ Skin Cancer
- ○ Other: _____

### STOMACH/INTESTINE

- ○ **NONE**
- ○ GERD
- ○ Ulcers
- ○ Crohn's Disease
- ○ Colitis
- ○ Diverticulitis
- ○ Irritable/Restricted Bowel Syndrome
- ○ Colon Cancer
- ○ Polyps Gallstones
- ○ Pancreatitis
- ○ Nausea/Vomiting
- ○ Other:_____

### EAR/NOSE/THROAT/ EYES

- ○ **NONE**
- ○ Ringing in Ears
- ○ Vision Problems:
  - ___ Glasses
  - ___ Cataracts
  - ___ Colorblind
  - ___ Glaucoma
- ○ Difficulty Swallowing
- ○ Nose Problems
- ○ Other: _____

### ENDOCRINE

- ○ **NONE**
- ○ Thyroid Disease
- ○ Diabetes:

__ Type I __ Type II

- ○ Pituitary Disease
- ○ Adrenal Disease
- ○ Overweight
- ○ Allergies
- ○ Hypoglycemic
- ○ Unexplained Weight Loss
- ○ Other: _____

### PSYCHOLOGICAL/ PSYCHIATRIC

- ○ **NONE**
- ○ Depression
- ○ Anxiety
- ○ Schizophrenia
- ○ Phobia
- ○ Addiction: _____
- ○ Other: _____

### OTHER

- ○ Fatigue
- ○ Loss of Balance/ Coordination
- ○ Allergies

___ Latex ___Seasonal
___ Drugs: _____

- ○ History of Falls
- ○ Cancer
- ○ Dizziness/Fainting/ Vertigo
- ○ Low Exercise Level
- ○ Other: _____

WORK: Are you currently working? ___ Yes ___ No If yes, how many hours per week? _____

Please describe what you do for work: _____

**I have read and reviewed the information herein and represent that my answers are true, correct and complete. I understand the Vitality SarcoHealth health practitioners are relying upon the information in rendering treatment.**

_____ _____

Client Signature Date