Vitality SarcoHealth™

Scheduled for: Initial Visit @ Time with Provider

ENROLLMENT INFORMATION				
First Name		**Last Name**		**M.I.**
Address		City	State	Zip
DOB / /	Age	Male Female	**SS #** - -	
Home Ph. #	**Cell Ph. #**		**Email**	
Employer		Occupation		
How Did You Hear About Us?				

EMERGENCY CONTACT INFORMATION	
Name	Relationship
Home Phone #	Alternate Phone #

PROVIDER CARE INFORMATION	
Referring Physician	Referring Physician Phone #
Injuries	**Surgery** Yes No Date: / /

INSURANCE INFORMATION			
Name of Primary Insurance		**Insurance Phone #**	
Subscriber's Name		**DOB** /	
ID #	**Group Policy #**		
Relationship to Patient Self Spouse Child Other			
Name of Secondary Insurance			
Subscriber's Name		**DOB** /	
ID #	**Group Policy #**	Relation: Self Spouse	

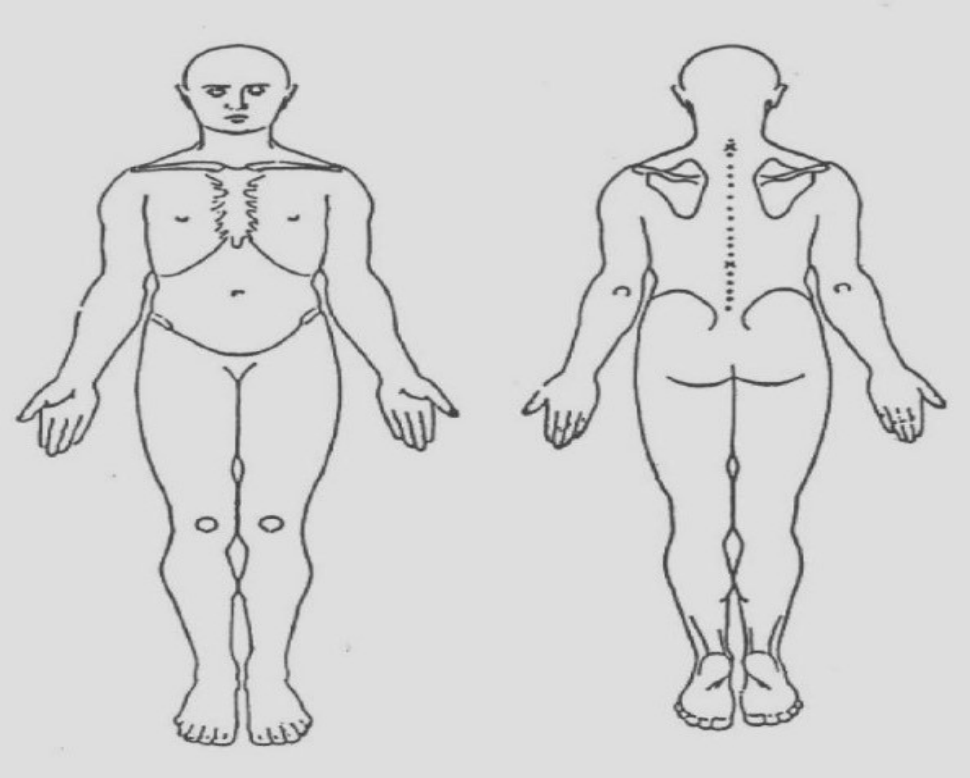
MISCELLANEOUS INFORMATION
Is it OK to leave message or voicemail at the phone number you provided? Yes No
Would you like to receive email appointment reminders? Yes No
Have you received Physical Therapy services in the past 12 months? Yes No
If yes, when were the services received?
Do you have a Pacemaker? Yes No
Do you have a **DO NOT RESUSCITATE (DNR)? Yes No** If yes, please inform staff.

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

X SIGNATURE _____

NAME _____ **DATE** _____

PRESENT CONDITION: PAIN / TENSION



Please place an "X" in the area or areas where you are experiencing pain / symptom. Use the descriptions of pain below to indicate the type of pain in each area that you marked by drawing an arrow from each specific type of pain to the "X".

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 being no pain and 10 needs to be taken to the hospital).

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_____

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

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

Since it has started, has the pain changed? Yes No

Have your symptoms become: Worse_____Better_____The Same _____

How often do you experience the pain? _____

Are you taking any medication? Yes No

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

_____

_____

_____

MEDICAL HISTORY: *Please circle any that apply to you and add start/stop dates.*

HEART/BLOOD VESSELS	BRAIN & NERVES	STOMACH/INTESTINE	LUNGS
• **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 Heartbeat • DVTs • Edema • Other: _____	• **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: _____	• **NONE** • GERD • Ulcers • Crohn's Disease • Colitis • Diverticulitis • Irritable/Restricted Bowel Syndrome • Colon Cancer • Polyps Gallstones • Pancreatitis • Nausea/Vomiting • Other: _____	• **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	**BLOOD DISORDERS**	**SKIN DISORDERS**	**JOINT/SKELETON/ MUSCLE**
• **NONE** • Stones • Kidney Failure/ Dialysis • Bowel/Bladder Issue • Urinary Tract Infection • Hepatitis A B C D • Cirrhosis • Other: _____	• **NONE** • Anemia • Sickle Cell Anemia • Bleeding Disorder • History of Blood Transfusions • Clot • Myelodysplastic Disorder • Other: _____ _____ _____	• **NONE** • Acne • Eczema • Psoriasis • Warts • Shingles • Skin Cancer • Other: _____	• **NONE** • Joint Pain • Surgery: ___ Knee ___ Hip ___ Shoulder ___ Back ___ Ankle ___ Neck • Osteoporosis • Fractures • Osteoarthritis • Gout • Scoliosis • Metal Implants • Fibromyalgia • Rheumatoid Arthritis • Other: _____
EAR/NOSE/THROAT/ EYES	**ENDOCRINE**	**PSYCHOLOGICAL/ PSYCHIATRIC**	**OTHER**
• **NONE** • Ringing in Ears • Vision Problems: ___ Glasses ___ Cataracts ___ Colorblind ___ Glaucoma • Difficulty Swallowing • Nose Problems • Other: _____	• **NONE** • Thyroid Disease • Diabetes: __ Type I __ Type II • Pituitary Disease • Adrenal Disease • Overweight • Allergies • Hypoglycemic • Unexplained Weight Loss • Other: _____	• **NONE** • Depression • Anxiety • Schizophrenia • Phobia • Addiction: _____ • 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 at your job: _____

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

Patient's Signature _____Date _____

Vitality SarcoHealth™

OFFICE POLICIES

CONSENT FOR CARE & TREATMENT: I consent and authorize Vitality SarcoHealth to perform physical evaluation, Physical Therapy, Strengtherapy® exercise and related services. In so doing, I understand, acknowledge and affirm services may involve bodily contact, touching and / or direct contact. INITIAL _____

CONSENT TO RELEASE / OBTAIN MEDICAL INFORMATION: Permission is hereby granted to Vitality SarcoHealth to release information to my insurance company, and physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have previously been treated to release medical records to Vitality SarcoHealth. INITIAL_____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Vitality SarcoHealth to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered. All payments received will be applied to my balance. I will be responsible for all copays/co-insurance and deductibles that may apply. Vitality SarcoHealth will provide a complimentary benefit analysis of benefits and will assist in understanding my benefits. It is my responsibility and I will not hold Vitality SarcoHealth responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me. INITIAL _____

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered. INITIAL _____

CANCELLATION & NO-SHOW POLICY: Please be aware that we require a 24-hour notice for cancelling an appointment. The charge for cancellation without proper notice is $40 for a physical therapy visit. Credit card information to be used in this case will be collected on your initial visit. Please see our Cancellation Policy form for additional details. INITIAL _____

NON-SUFFICIENT FUNDS: Checks returned to Non-Sufficient Funds may be subject to a $25 processing fee. INITIAL _____

FINANCIAL POLICY: As a courtesy to you, we will bill your insurance carrier. You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill. INITIAL ___

Courtesy Insurance Benefit Check, completed by: _____ Date: _____

[Estimated] Deductible $ _____ / year; Co-Pay $ _____ / visit; Co-Insurance $ _____ / visit; Visit Limit: _____

Payment Agreement: _____ will be paid each visit

Notes: _____

_____

**For added convenience of re-occurring co-pays and co-insurance, we are providing automatic transactions through our Triib Secure Patient Payment System on the credit card you authorize*

The above financial information has been read and explained to me and I understand my responsibility for payment of my account.

_____ _____

X Signature **Date**

_____ _____

X Vitality SarcoHealth Representative **Date**

Vitality SarcoHealth™

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

I understand Vitality SarcoHealth is required by law to keep my health information confidential. With my signing of this form, I am giving consent that Vitality SarcoHealth may use and disclose protected health information (PHI) about me to carry out treatment, payment, co- ordination of care, and other healthcare operations. If I wish to know more about its privacy practices, I shall refer to Vitality SarcoHealth Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review and request a copy of the No- tice of Privacy Practices prior to signing this consent. I understand that Vitality SarcoHealth reserves the right to revise its Notice of Privacy Practices at any time.

I have the right to request a copy of my personal health information. I have the right to be notified when it has been determined that a breach of my unsecured PHI has occurred. I understand this authorization is voluntary. According to HIPAA regulations, Vitality SarcoHealth may not release information about me to my family, friends without my written consent. I may revoke this authorization at any time, provided that I do so in writing.

Any concerns I have regarding any violation of my privacy rights will be communicated to a Vitality SarcoHealth Compliance Officer. I also have the right to report any concerns I have with my privacy rights to the Office of Civil Rights, U.S. Department of Health and Human Services.

The notice contains a patient's rights section describing your rights under the law. I ascertain that by my signature, I have reviewed our notice before signing this consent.

I have the right to restrict how my protected health information is used and disclosed for treatment, payment or healthcare operations. Vitality SarcoHealth is not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If we may have permission to share details of your medical condition with specific individuals, please list the name(s) allowed below:

_____

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

INFORMED CONSENT

I seek the services of Vitality SarcoHealth and its employees. 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 by 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, 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, claims or guarantees that my medical or health problems or conditions will be helped 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 compatible.

I understand that my treatment with Vitality SarcoHealth may include recommendations that I seek other types of treatment or services from other health professionals who are not affiliated with Vitality SarcoHealth. I understand that Vitality SarcoHealth does not supervise these professionals and is not responsible for them.

I certify that I have read and understood the foregoing Informed Consent. If its contents raised questions for me, I have asked and received satisfactory answers to my questions. I hereby agree to and accept all of the terms above.

Name: _____ **Signature:** _____ **Date:** _____

For Office Use Only:

I have explained this Informed Consent and answered all questions, and informed the client of the available alternatives and of the potential risks. To the best of my knowledge, the client has been adequately informed and has consented.

Vitality SarcoHealth Signature: _____ *Date:* _____

Vitality SarcoHealth™

Missed Appointment & Cancellation Policy

At Vitality SarcoHealth, our mission is to Redeem Aging. You may recognize quickly that we are different than rehab facilities that you may have visited in the past. Our center operates on a one-on-one therapist/patient model, that you do not often see in other facilities, and it is our hope that you will find great value and benefit in this type of care.

We understand that we all experience unanticipated events. Last minute travel plans, family in town, car problems, physician appointments and illness are just a few of the reasons why one might consider cancelling an appointment. When you miss an appointment with us, we not only lose time with you, but we also potentially lose time with another patient, who could have scheduled an appointment at that time. In our desire to be effective and fair to all of our patients, and out of consideration for our therapists' time, we have adopted the following policy:

Twenty-four hour advance notice is required when cancelling an individual appointment. If you are unable to give us the minimum 24-hours advance notice, and we are unable to fill your time slot, you will be charged a $40 cancellation fee. This fee will automatically be charged to the credit card you have on file.

We recognize that the time of our clients and staff is valuable and have implemented this policy for this reason. We appreciate your understanding in this matter. Please sign below that you have read, understand and agree to this Cancellation & Missed Appointment Policy and that you approve the use of the credit card on file should such a case occur.

Signature of Patient /Member_____ Date _____

Vitality SarcoHealth Witness _____Date_____

Vitality SarcoHealth™

Credit Card Authorization

As you know, if you have ever checked into a hotel or rented 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.

We implement a similar policy. You will be asked for a credit card number at your initial appointment and the information will be held encrypted until your insurances have paid their portion and have 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.

Missed appointments, appointments cancelled without 24-hour advance notice and/or late charges will also be charged to the card on file. Please review our Missed Appointment & Cancellation Policy for details.

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 credit card information.

If you have any questions about this payment method, do not hesitate to ask.

I, _____, authorize Vitality SarcoHealth to charge outstanding balances and/or late cancellations or missed appointments on my account to the following credit card which has been given **(Please circle)**:

AMERICAN EXPRESS **VISA** **MASTERCARD** **DISCOVER**

SIGNATURE:_____ **DATE:**_____

Falls Efficacy Scale

Name: _____ Date: _____

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you can do the following activities without falling?

Activity	**Score** 1 = Very confident 10 = Not confident at all
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals (not requiring carrying heavy or hot objects)	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e., washing your face)	
Getting on and off of the toilet	
Total Score	

References:

Tinetti, M., D. Richman, et al. (1990). "Falls efficacy as a measure of fear of falling." Journal of Gerontology **45**(6): P239.