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 nursing or physical therapy, 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.

Patient Signature _____ Date _____

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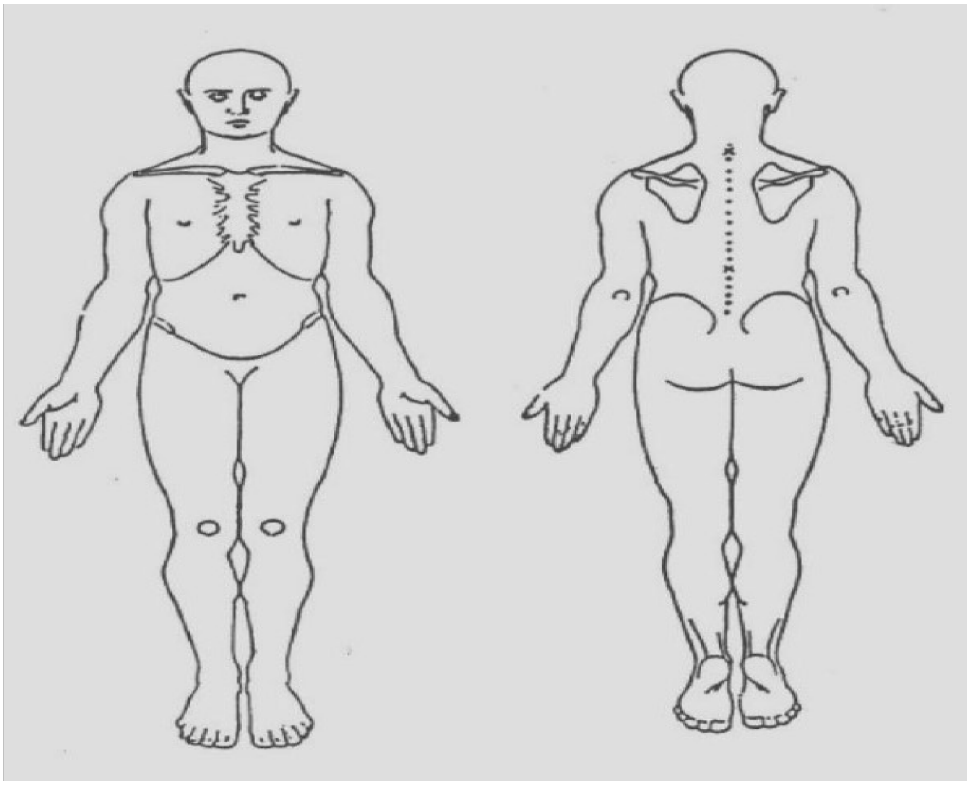
Patient Name: _____ Date: _____

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: _____

_____

_____

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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 accurate, correct, and complete. I understand Vitality SarcoHealth health practitioners rely upon this information when rendering treatment.

_____ _____

Patient Signature Date

Vitality SarcoHealth™ Clinics

INFORMED CONSENT

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

1. Benefits of Treatment with Vitality SarcoHealth

I understand that services and treatments offered by Vitality 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 may carry certain risks. I understand that the physical response to a specific treatment can vary widely from person to person, and 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 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, I should raise these with my physical therapist or another Vitality representative.

3. Alternatives

I understand that my health care provider may recommend alternatives to services from Vitality 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 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. I understand that my failure to comply with treatment recommendations may impede results.

I am responsible for disclosing to Vitality all medications, care, and assessments that I receive elsewhere and providing 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.

I understand that Vitality will perform a physical evaluation, provide physical therapy and/or sarco (muscle and strength) therapy 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 if any contact makes me feel uncomfortable.

5. Consent to Release/Obtain Medical Information: I authorize Vitality 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.

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, and I received satisfactory answers to my questions. I hereby agree to and accept all of the terms above.

Patient 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 Rep 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 Patient	Phone Number
Name	Relationship to Patient	Phone Number

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.
PLEASE READ CAREFULLY.

How Vitality Health May Use and Disclose Your PHI

- ActiveRx Inc. dba Vitality SarcoHealth ("Vitality") is required by law to keep your health information confidential and to inform you of how your information may be used or disclosed.
- Vitality 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 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 restrict how it uses and discloses your PHI though Vitality 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 complaint 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'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 facilities.

Patient Signature	Print Name	Date

Vitality SarcoHealth™ Clinics

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICIES

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

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

Automobile & On-the-job Injuries: 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.

Financial Policies:

- I understand that Vitality is out of network with most insurance carriers other than Medicare.
- I understand that while Vitality will verify and bill my insurance as a courtesy to me, I am ultimately responsible for payment if my insurance company provides inaccurate or incomplete information to Vitality that causes their claims to be denied.
- I understand that in scheduling an appointment, I am accepting full responsibility for all copays/co-insurance, deductibles, and late cancelation/no-show/late fees that I may incur.
- I understand that Vitality requires a credit card to be stored in its secure, encrypted system for all patients, and I authorize Vitality to charge my credit card for all co-pays/co-insurance, deductibles, and late cancelation/no-show/late fees that have been communicated to me in advance.
- I understand that it is my responsibility alone to notify Vitality immediately if I make any changes to my insurance plan(s) during the course of my treatment.
- I understand that in the rare event my insurance carrier recoups or requests a refund of any payments made to Vitality (e.g., my carrier pays the claim for services but later determines that the services are not a benefit under my health plan), I will reimburse Vitality.
- I understand that if my insurance carrier sends any payment directly to me for services billed by Vitality, this money does not belong to me, and I will promptly remit the payment(s) to Vitality.
- I understand that if formal collections procedures become necessary, Vitality has the right to pass any reasonable costs for these services through to me.
- I understand that checks returned due to insufficient funds may be subject to a $25 processing fee.

We will provide you with a good faith estimate of your health benefits to help you understand what services are covered/not covered and any co-payments, co-insurance, or deductibles we are required to collect from you. By signing below, you are acknowledging that you understand the information we provided to you and agree to the Assignment of Benefits and the summary of the financial and organizational policies within this document, which are further detailed in our Terms of Services page of our website (**choosehowyouage.com/terms-of-service**).

Patient 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 will ask for you to swipe or tap your credit card at your initial appointment, and our highly secure, encrypted system will store your credit card information.

This will be an advantage to you since you will not have to worry about forgetting your purse or wallet. When you come in for follow-up appointments, our patient care coordinator will charge the co-pay or co-insurance amount that you were previously made aware of and authorized.

This credit card policy will not compromise your ability to dispute an incorrect charge or to question your insurance company's coverage. 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.

It is imperative for us to operate efficiently to conserve unnecessary costs. This goes a long way toward ensuring we will continue to be able to offer you the quality one-on-one care that produces the life-changing results that you desire, and we have built our reputation over the past 20 years.

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

_____	_____	_____
Patient Signature	Print Name	Date