Welcome,

Allow me to be the first person to welcome you to our family at TheraFit Rehab. I say that, because it's truly the way we feel. From your very first interaction with us, we want you to feel how valued and important you are. From the moment, you choose our facility to provide for your therapy & fitness needs, you become like one of the family.

And we're so glad to have you on board!

Therafit Rehab takes pride in each and every member and we are dedicated to providing therapeutic exercise and activity based rehabilitation to people of all ages and disabilities.

Because we value you as a person, our company is based around three basic philosophies:
1. You deserve our utmost attention in fulfilling your needs
2. Every interaction with our staff should leave you smiling
3. We want to get your results faster than ever, exceed your expectations and earn your goodwill for life

It's because of people like you that we enjoy doing what we do. It is our phenomenal customers that make this company great. And, we try to reflect that in every interaction we have with you.

As a valuable part of the family, we want all of your experiences to be exceptional ones. In fact, you should be so content with our service that you can't help but tell your friends and family about us.

Again, welcome! And, thank you for choosing TheraFit Rehab!

Please feel free to contact us with any concerns or questions you may have. We are always willing to go out on a limb for you!

Sincerely,

The staff at TheraFit Rehab!

THERAFIT THERAPY + FITNESS Rehab

Specializing in Neurological Disorders
www.TheraFitRehab.com

NEW PATIENT INFORMATION

It is pertinent that ALL fields are completed in their entirety.

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

DEMOGRAPHIC INFORMATION	
Name: (Last, First, MI, Suffix) ☐ **M** ☐ **F** **Nickname: (if any)**	
Date of Birth:	**Height:**
Address:	**Weight:**
City: **State:** **Zip Code:**	**Social Security Number:**
Phone Numbers: **Home:** **Cell:** **Work:**	
E-mail Address:	
How did you hear about TheraFit Rehab?	
****Have you received Home Healthcare in the past month? **** ☐ Yes ☐ No If yes, what agency were you with? _____ Phone Number _____	
Occupation:	
Employment status: ☐ Full Time ☐ Part Time ☐ Student ☐ Retired	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Emergency Contact: **Relationship:** **Phone number:**	

REFFERING PHYSICIAN	
Name:	
Phone:	**Fax:**
Address:	
City: **State:** **Zip Code:**	
Date of Last Physical Exam:	
ASSOCIATED CARE INFORMATION	
Company/Residence:	**Address:**
Caregiver's Name:	**Phone:**

HEALTH INSURANCE INFORMATION	
Primary Insurance:	
Referral/ Authorization Required: ☐ Yes ☐ No	Phone:
ID#:	Group #:
Policy Holder: ☐ Self ☐ Other: Name_____ DOB:_____	
Secondary Insurance:	
Referral/ Authorization Required: ☐ Yes ☐ No	Phone:
ID#:	Group #:
Policy Holder: ☐ Self ☐ Other: Name_____ DOB:_____	
Tertiary Insurance:	
Referral/ Authorization Required: ☐ Yes ☐ No	Phone:
ID#:	Group #:
Policy Holder: ☐ Self ☐ Other: Name_____ DOB:_____	
Financial responsible party:	**Name:** **Phone Number:**

REHABILITATION INFORMATION

******Chief complaint/Injury****:**

_____

_____

Date of injury (Month/Year): _____Date of surgery (Month,

year):_____

Briefly describe how you were injured:

_____

_____

_____

Have you received physical therapy before? ☐ Yes ☐ No When? _____

PERSONAL HEALTH HISTORY		
Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunization and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

DIAGNOSED MEDICAL PROBLEMS: Check all that apply.

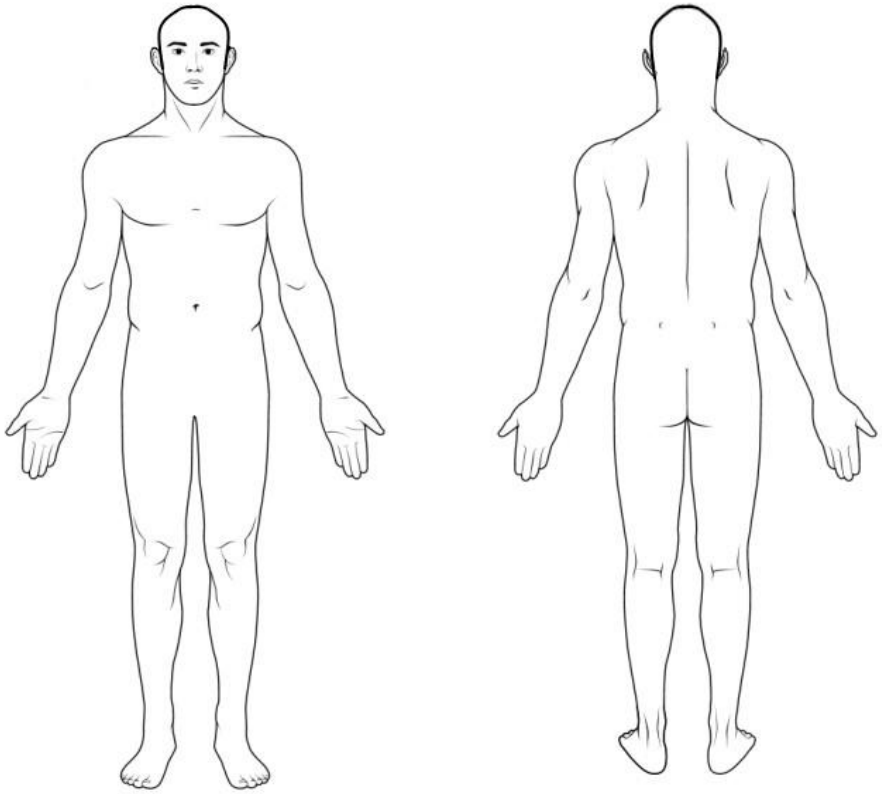
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ BLEEDING PROBLEMS
- ☐ BLOOD CLOTS
- ☐ CANCER
- ☐ DEPRESSION/ANIXETY
- ☐ DIABETES
- ☐ DIFFICULTY SWALLOWING
- ☐ EPILEPSY/SEIZURE
- ☐ FEVER/CHILLS/SWEATS
- ☐ FIBROMYALGIA
- ☐ HEART TROUBLE
- ☐ HIGH BLOOD PRESSURE (HYPERTENSION)
- ☐ HISTORY OF ALCOHOL ABUSE
- ☐ HISTORY OF DRUG ABUSE
- ☐ HISTORY OF SMOKING
- ☐ HIV/HEPATITIS
- ☐ MOTION SICKNESS
- ☐ MYOFASCIAL PAIN
- ☐ OSTEOPOROSIS
- ☐ PACEMAKER
- ☐ PREGNANCY
- ☐ SHORTNESS OF BREATH
- ☐ STROKE
- ☐ UNEXPLAINED WEIGHT LOSS
- ☐ OTHER: Please explain

SURGERIES (Please list any implants. If you need more room, please attach to back of these pages.)		
Month, Year	Reason	Hospital
OTHER HOSPITALIZATIONS		
Month, Year, Length of Stay	Reason	Hospital
MEDICATIONS: List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.		
Name of the drug	Strength	Frequency Taken

ALLERGIES: To Medications or Latex	
Name the Drug	Reaction You Had

PAIN ASSESSMENT

MARK AREAS OF PAIN WITH 'X'. CHECK OFF ALL TYPES OF PAIN THAT APPLY. If you are completing this form on the computer, print form and mark diagram with a pen.



- ☐ **Dull Ache**
- ☐ **Radiating**
- ☐ **Numb/Tingling**
- ☐ **Burning**
- ☐ **Sharp**
- ☐ **Stabbing**
- ☐ **Throbbing**
- ☐ **Constant**
- ☐ **Intermittent**

Mark the number that best corresponds to your pain.

At Worst:	(No pain)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 (Excruciating pain)
Current:	(No pain)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 (Excruciating pain)
At Best:	(No pain)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 (Excruciating pain)

What decreases pain/makes your condition better? (Mark all that apply)

☐ Sitting	☐ Changing Positions	☐ Rest	☐ Better in AM
☐ Standing	☐ Prolonged Positioning	☐ Heat	☐ Better as day progresses
☐ Rising	☐ Walking	☐ Ice	☐ Better in PM
☐ Lying	☐ Movement	☐ Medication	☐ Other_____

What increases pain/makes your condition worse? (Mark all that apply)

☐ Sitting	☐ Prolonged Positioning	☐ Sneeze/Cough	☐ Worse in AM
☐ Standing	☐ Walking	☐ Deep Breath	☐ Worse as day progresses
☐ Rising	☐ Stairs	☐ Heat	☐ Worse in PM
☐ Lying	☐ Movement	☐ Ice	☐ Other_____
☐ Changing Positions	☐ Rest	☐ Medication	

HEALTH HABITS AND PERSONAL SAFETY				
Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e. climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 mins)			
	☐ Regular vigorous exercise (i.e. work or recreation 4x/week for 30 mins)			
Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed diet?		☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	How many drinks per week?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes- pk/day?	☐ Chew- #/day?	☐ Pipe- #/day?	☐ Cigars- #/day?
	# of years?	Or year quit?		
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have a history of falls?		☐ Yes	☐ No
	If yes, please describe (indicate frequency)			
	Have you experienced dizziness or lightheadedness?		☐ Yes	☐ No
	Do you have vision loss?		☐ Yes	☐ No
	Do you have hearing loss?		☐ Yes	☐ No

FAMILY HEALTH HISTORY					
	AGE	**SIGNIFICANT HEALTH PROBLEMS**		**AGE**	**SIGNIFICANT HEALH PROBLEMS**
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	

MENTAL HEALTH		
Is stress a major problem for you? If yes, what are your stressors?	☐ Yes	☐ No

Do you feel depressed?	☐ Yes	☐ No
PERSONAL INTEREST AND PERSONAL FITNESS GOALS		

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESSS TO THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY.

OUR LEGAL DUTY
TheraFit Rehab is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION
TheraFit Rehab uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing tracking, and research studies. In any other situation, TheraFit Rehab will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatment, payment or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. TheraFit Rehab will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS
If you are concerned that TheraFit Rehab may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Gina Gilligan, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

TheraFit Rehab
HIPAA Compliance Office
Attn: Gina Della
511 Jermor Lane Ste 102
Westminster, MD 21157
(410)871-2494

INITIAL _____

24 Hour Appointment Cancellation and Late Policy

TheraFit Rehab has a 24-hour Cancellation and Late Policy. This policy is for all members of TheraFit Rehab and is in place out of respect for our therapists and our patients.

CANCELLATIONS: We ask that you give us 24-hours' notice if you must cancel an appointment. We reserve time in our schedule specifically for you and we ask for your cooperation by making every effort to keep scheduled appointments. Cancelled appointments must be rescheduled for another day in the same week or the week after, in order to avoid being charged a fee. If you cannot reschedule or do not cancel within less than 24 hours', you will be charged $50 for that session. Failure to show up at all for an appointment ("No show") will result in an automatic fee of $50. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.

LATE ARRIVALS: Please arrive on time for your scheduled appointments. Late arrivals are disruptive and if you are more than 15 minutes late for your appointment, treatment may be cancelled due to scheduling and a $50 fee charged for missing the appointment.

Consistent attendance of all therapy sessions is very important to your overall success here. It is also known that your therapy treatments should be taken very seriously, as it pertains to your insurance, justifying your need for therapy. Missed appointments will not justify the need for therapy and its necessity for your medical condition. Maintaining regular treatment sessions is essential for positive outcomes. Repeated cancellations and/or no shows will hinder your care and may result in discharge from your therapy program.

No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled. Please note that the patient is responsible for the fee, not the insurance company or third-party payer.

INITIAL _____

Appearance Release

I authorize TheraFit Enterprises, Inc. (hereinafter referred to as "TheraFit Rehab") to use photographs, videotapes or other likenesses of me for advertising and/or promotional purposes.

I agree that you may videotape and/or photograph me and record my voice, conversation and sounds and that you shall be the exclusive owner of the products of such taping, photography and recording with the right to use all or any portion thereof.

I further agree that you may use my full name, voice, likeness and any biographical or other written material concerning me in the promotion, advertising, sale, publicizing and/or otherwise in connection with TheraFit Rehab or the Quadriciser. I further represent that any statements that I would make would be true, to the best of my knowledge, and that neither they nor my appearance will violate or infringe upon the rights of any third party.

I hereby waive any right of inspection or approval of my appearance or the uses to which such appearance may be put. I also waive any right to reimbursement, compensation or other remuneration for TheraFit Rehab use of my photographs, likeness or appearance. I acknowledge that you will rely on this permission, and I hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permission granted hereunder. I also acknowledge that I may revoke this release by writing to TheraFit Rehab; however, a revocation will be effective only as to any future uses of my likeness or appearance and does not require TheraFit Rehab to cease using any promotional materials already in use, print, production, or distribution before receipt of a revocation that bears my likeness or appearance.

Name_____ Date _____

Signature_____

I am parent (or guardian) of the minor/disabled who has signed this release and consent and I hereby agree that I and the said minor/disabled will be bound by all the provisions contained herein.

Name_____ Date_____

(Signature)

Payment Policy

_____ **PRIMARY INSURANCE** - We will bill your primary insurance as a courtesy to you. We assume payment of **insurance** benefits is **not forthcoming on charges older than** 60 days. **Charges outstanding for more than sixty days will be due in full from you regardless of the type of insurance involved.** Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your insurance benefits. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. Secondary insurance will be your responsibility to file and collect.

_____ **MEDICARE** - We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

_____ **SELF PAY** - Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that TheraFit Rehab is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Credit cards (MasterCard and Visa) are accepted for payment on account.

_____ **WORKERS' COMP** - We will bill your Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

_____ **LEGAL SUIT** - We will accept a legal letter of protection if you meet each of the following criteria:

1) Do not qualify for benefits under any insurance policy (medical or auto), and
2) Are indigent and cannot pay for charges due using cash or credit card, and
3) Are awaiting settlement and subsequent payment of damages from a related legal case, and 4) Return our lien, signed by both you and your attorney.

Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 90 days from the date of last treatment. Upon settlement of your legal case, your balance in full is due within 30 days. Please be aware that you will remain financially responsible for services rendered regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principal amount owing, and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, and all court costs and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest on balances over 30 days old, charge returned check fees as allowed by state law, and charge a no-show fee for missed appointments when adequate notice of cancellation is not provided. Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

CANCELLATION POLICY: To maintain appointment times available for all of our patients, there is a charge of $50.00, *BILLED TO THE PATIENT*, for each instance a patient does not show for a scheduled appointment or does not give at least 24-hour cancellation notice.

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to TheraFit Rehab in the event they file insurance on my behalf; I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is there in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (12% annually) for unpaid balances over 30 days old. I hereby authorized said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of TheraFit Rehab as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

INITIAL _____

Patient Consent

Patient Name:_____ Date:_____

Authorization for Treatment

I hereby give my permission for authorized personnel of TheraFit Rehab to perform all necessary procedures and treatments as prescribed by my physician for the delivery of outpatient physical therapy. I understand that I may refuse treatment or terminate services at any time and the agency may terminate their services to me as explained to me in my orientation.

Release of Information

I authorize TheraFit Rehab to release to or receive from hospitals, physicians, insurance carriers, healthcare carriers, or other agencies involved in my care all medical or other information pertinent to my care. I hereby give permission for the review of my medical record by regulatory.

Authorization for Payment

I authorize payment of medical benefits from Medicare or other responsible payor to be made in my behalf to the undersigned provider. I understand that I am responsible for all amounts not paid by my insurance.

Consent to Photograph

I hereby authorize TheraFit Rehab to take pictures of myself and treatment being done and authorize release of the photographs to insurance providers or my physician in order to document my medical condition.

Name_____ Date _____

Signature_____

I am parent (or guardian) of the minor/disabled who has signed this release and consent and I hereby agree that I and the said minor/disabled will be bound by all the provisions contained herein.

Name_____ Date_____
(Signature)

Signing this form indicates consent to all above mentioned terms including our **24 Hour Appointment Cancellation and Late Policy, Appearance Release, Payment Policy, Patient Consent** and that the formal office **HIPAA policy and procedures** have been reviewed to the above-noted patient and that a copy of the policy was provided to the patient.