PATIENT INFORMATION FORM

Name:_____ Birthdate:_____ Age:_____ Sex:_____
LAST FIRST MIDDLE
Home Address: _____ City:_____ State:_____ Zip:_____

Home Ph. #:_____ Work Ph. #:_____Cell Ph. _____
FOR REMINDER CALLS, PLEASE MARK WHICH # YOU PREFER TO BE CONTACTED:
CELL: ◯ HOME: ◯ WORK: ◯ DO NOT CONTACT: ◯

If Workmans Comp, complete this section:
Employer Name: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip:_____

Work Ph. #: _____ Date of Injury:_____

If PPO, complete this section:
Name of Insurance Co.: _____ Group / Policy #: _____

Subscriber Name: _____ Relation to Patient: _____

Subscriber Birthdate: _____ Last 4 of SS #: _____

Subscriber Employer: _____ Phone # _____

Person to contact in case of emergency:
Name: _____ Relationship:_____
LAST FIRST MIDDLE
Address: _____ City:_____ State: _____ Zip:_____

Best available phone #: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for service provided or benefits for related service.
Date: _____ Signature of Patient: _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits to be made directly to Encore Wellness® for services provided to me by Encore Wellness ®. I understand that I am financially responsible to Encore Wellness® for charges not covered by this agreement. I authorize refund or overpaid insurance benefits where my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees. The membership fee is not refundable or transferable.
Date: _____ Signature of Patient: _____

AUTHORIZATION TO TREAT: I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the Physical Therapist.
Date: _____ Signature of Patient: _____

ENCORE WELLNESS®

RELEASE AND WAIVER OF LIABILITY

AND INDEMNITY AGREEMENT

IN CONSIDERATION of being permitted to utilize the facilities, services and programs of Encore Wellness® for any purpose, including, but not limited to, observation or use of facilities or equipment, or participation in any off-site program affiliated with Encore Wellness®, the undersigned, for himself or herself and any personal representatives, heirs and next of kin, hereby acknowledges, agrees and represents that he or she has inspected, or immediately upon entering or participating will inspect and carefully consider such premises and facilities of the affiliated program. It is further warranted that such entry into Encore Wellness®, observation or use of any facilities or equipment or participation in such affiliated program constitutes an acknowledgement that such premises and all facilities and equipment thereon and such affiliated program have been inspected and carefully considered and that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation by the undersigned.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER ENCORE WELLNESS® FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO, OBSERVATION OR USE OF FACILITIES OR EQUIPMENT, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING:

1. THE UNDERSIGNED HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE Encore Wellness®, its directors, officers, employees, and agents (hereinafter referred to as "releasees") from all liability to the undersigned and all his or her personal representatives, assignees, heirs and next of kin for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned due to any cause other than the willful misconduct or gross negligence of releasees while the undersigned is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with the Encore Wellness®.

2. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releasees and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about or participating in any program affiliated with Encore Wellness® due to any cause other than the willful misconduct or gross negligence of releasees.

3. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to any cause other than the willful misconduct or gross negligence of releasees while in, upon or about the premises of Encore Wellness® and/or while using the premises or any facilities or equipment thereon or participating in any program affiliated with Encore Wellness®.

4. THE UNDERSIGNED HEREBY ACKNOWLEDGES THAT AS PART OF ITS PROGRAM and in an effort to maximize the effectiveness of its programs on overall wellness, Encore Wellness® will periodically inform your physician of your progress

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THIS RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT and further agrees that no oral representations, statements or inducement apart from the foregoing written agreement have been made.

I HAVE READ THIS RELEASE

Date: _____ Signature of Applicant: _____

Print Name: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

OUR COMMITMENT TO YOUR PRIVACY
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office and that are otherwise brought to our attention. 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 office's personnel.

USES AND DISCLOSURES: We will use and disclose elements of your protected health information in the following ways without your signed authorization:
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.
Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. If necessary, information may be used for an outside collection agency to collect any balance due to this facility.
Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Nifty after Fifty.
Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.
Appointment Reminders: Our practice may use and disclose your personal health information to contact you to remind you of a scheduled or missed appointment. We will also use your health information to confirm your first appointment with this facility.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights: You have certain rights under the federal privacy standards. These include the right to:

- request restrictions on the use and disclosure of your protected health information. This must be done in writing, dated and signed by you.
- receive confidential communications concerning your medical condition and treatment by alternate means. This must be described in writing and signed and dated by you.
- inspect or receive copies of your protected heath information. This requires a signed and dated request and payment for the copies.
- amend or submit corrections to your protected health information. This must be a signed and dated request that we are not required to grant.
- receive an accounting of how and to whom your protected health information has been disclosed. This must be a signed and dated request.
- receive a printed copy of this notice at your request.

Duties of Nifty after Fifty: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to Nifty after Fifty, Attn: Privacy Practices, 1501 E Orangethorpe Ave., Suite 180Fullerton, CA 92831-5205. If you believe that your privacy rights have been violated, you should call the matter to our attention or you may also contact the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

Effective Date: This notice is effective on or after October 23, 2009.

I have received a copy of the above Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print Name

encorewellness
Physical Therapy

NIFTY after FIFTY 50 by encore wellness Customized Fitness • Physical Therapy

TO OUR VALUED PATIENTS

Due to the high demand for treatment at Encore Wellness Physical Therapy, we have implemented the following scheduling policies. Please make every effort to show up on time and keep your scheduled appointments. If you must cancel, please do so as far in advance as possible.

When the Initial Evaluation has been completed, a maximum of four (4) follow-up appointments can be scheduled. After the third appointment has been completed, your Physical Therapist will advise you how many additional visits to schedule.

We will make every effort to accommodate the treatment time you request, but please understand that it may not be immediately available.

If you show up late for your appointment, it is likely that your treatment time will be shortened.

If you must cancel an appointment, please give us as much notice as possible. An appointment cancelled more than 24 hours in advance will not result in any action for future appointments. However, two cancelled appointments less than 24 hours in advance, or not calling to notify us will result in all future appointments being removed from the schedule. If you call to re-schedule a follow-up appointment after not showing, or cancelling two or more times, you must wait for the next available open appointment slot on the schedule.

Adherence to this policy allows us to provide you with the most effective and efficient treatment.

_____ ____/____/_____

Patient Signature Date