

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Primary Care Physician: _____ Referring Physician _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Do you smoke? **YES NO**

Are you latex sensitive? **YES NO**

Do you have a pacemaker? **YES NO**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Have you **RECENTLY** noted any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> fainting |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> cough |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> headaches |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> constipation | |
| <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> diarrhea | |

Have you **EVER** been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Other arthritic condition | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bladder/urinary tract infection | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye irritation/infection | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Sexually transmitted disease/HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Recent Infection | <input type="checkbox"/> Incontinence | |

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

ALLERGIES: List any medication(s) that you are allergic to: _____

Have you had any of the following for your current problem: X-Ray Injection MRI CT Scan

Have you received Home Health Therapy for this problem? **YES NO** If yes, Date of last visit _____

Are you currently being treated by a chiropractor? **YES NO**

(Please Complete Reverse Side)

Date of Injury or Surgery _____ Body Part Affected _____

Are you on a work restriction from your doctor? **YES** **NO**

What do you think caused your symptoms? _____

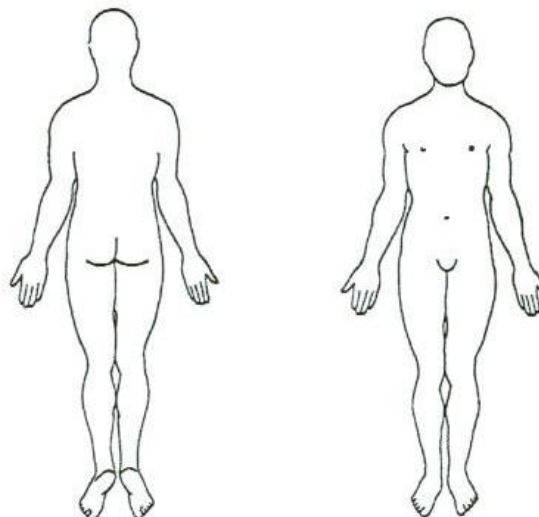
Have you ever had this problem before? **YES** **NO** When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ξξξξ Numbness
- = Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

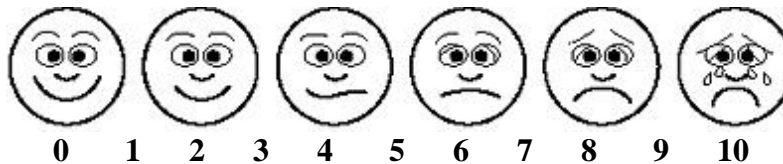
How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms **worst**? Morning Afternoon Evening Night After exercise

When are your symptoms the **best**? Morning Afternoon Evening Night After exercise

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:



Your **CURRENT** level of pain while completing this survey: _____

The **BEST** your pain has been during the **past 24 hours**: _____

The **WORST** your pain has been during the **past 24 hours**: _____



CONSENT TO TREAT AND CONDITIONS OF ADMISSION

1 CONSENT TO REHABILITATION PROCEDURES: The undersigned consents to the procedures which may be performed during this and future out patient physical therapy visits that are performed at Proaxis Therapy.

2 LEGAL RELATIONSHIP BETWEEN PROAXIS THERAPY PHYSICAL THERAPISTS: All Physical Therapists, and Physical Therapist assistants are employed by Proaxis Therapy, LLC.

3 RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Proaxis Therapy may make available certain basic information about the patient in accordance with HIPPA regulations, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning or other condition) general nature of the injury, burn, poisoning or other condition, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Proaxis Therapy for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Proaxis Therapy may disclose portions of the patients record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Proaxis Therapy's charges, including but not limited to government agencies (e.g., Medicare, Medicaid, insurance companies, health care service plans, or workers compensation carriers). By signing below, I acknowledge that I have received Proaxis Therapy's Notice of Privacy Practices.

4 FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Proaxis Therapy in accordance with the regular rates and terms of Proaxis Therapy. All accounts are handled by an independent billing company, including billing, collections and all other matters relating to the account.

5 ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Proaxis Therapy of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, at rate not to exceed Proaxis Therapy's regular charges. It is agreed that payment to Proaxis Therapy, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. **Any pre-certification of insurance benefits is the patients sole responsibility.** The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient for all services furnished by Proaxis Therapy. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

6 AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR PAYMENT:

I hereby authorize the release of all information from the patients medical record that may be necessary to make reimbursement or payment for any or all the services rendered by the Therapist involved in my care with Proaxis Therapy. I hereby authorize my Insurer or any third party responsible for the payment of covered medical/surgical benefits on my behalf to make payment directly to Proaxis Therapy. As a patient I understand that I am responsible for my insurance benefits and understand my in network and out of network coverage.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patients legal representative, or is duly authorized by the patient as the patients general agent to execute this document and accept and agree to its terms.

Patient / Guardian Signature

Date

Print Patient Full Name

FINANCIAL POLICY FOR PROAXIS THERAPY

As a courtesy to our patients, we check the insurance coverage and benefits for therapy services; however, it is the patient's responsibility to verify coverage, understand their particular insurance and insure that payment is made.

Therapy services are billed on time based procedure codes. Your therapist will perform a variety of activities with you in order to maximize your recovery and help you to reach your goals. The therapist will choose the appropriate charge codes based on the activities that are performed and how much time is spent on each procedure or activity.

In the information below, we are ESTIMATING the amount of money you will need to pay after you insurance has been filed. The information below does not guarantee insurance coverage or insurance payment. When insurance benefits are verified, the insurance company does not guarantee payment. If the insurance company denies coverage, you will receive a bill for those services.

Proaxistherapy does not accept third party liability insurance. If you have been involved in an accident where there is third party coverage, you will be responsible for paying for therapy services rendered by proaxistherapy at the time that services are rendered and collecting from the third party.

The amount not covered by the primary insurance company is estimated below. That amount is payable on the date that services are rendered. This estimate is determined by benefits from your plan or from a predetermination from your insurance company. Please understand that this is only an estimate and that insurance companies have their own schedule of what they consider to be "usual and customary". These fees often vary between plans. Our charges are based solely on the amount of time, skill and care that is provided by your therapist for each individual treatment session. Therefore, it is not uncommon to find a difference in our charges and the insurance payment. If we are in network for your insurance carrier, you will be responsible for the insurance allowable. If we are not in network for your insurance, you will be responsible for the difference between the allowable and the charge. Please understand that your insurance is an agreement between you, your employer and the insurance carrier.
PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED.

The information below is provided as a courtesy to you but is an ESTIMATE of your insurance benefits and does not guarantee insurance payment. If you have NOT met your deductible, we will take a deposit from you towards your deductible at each visit until you meet the deductible. You will receive a bill for the difference between the deposit and the insurance allowable after the insurance has communicated the allowable. If you have had a recent procedure that should apply to your deductible, it may not have been billed by the hospital or physician's office and therefore, may not be listed when we checked your benefits. If you have a co-insurance percentage that you are expected to pay, we will collect an estimated amount on that co-insurance and you will receive a bill for the difference between what you paid and what the insurance company allows. We encourage you to contact your insurance company to better understand your benefit for therapy services.

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> We ARE contracted with your insurance company <input type="checkbox"/> Your individual deductible is \$ _____ <input type="checkbox"/> You have met \$ _____ of your individual deductible <input type="checkbox"/> Your family deductible is \$ _____ <input type="checkbox"/> You have met \$ _____ of your family deductible We require a payment of \$ _____ towards your deductible | <ul style="list-style-type: none"> <input type="checkbox"/> We are NOT contracted with you insurance company <input type="checkbox"/> Your copay for each visit is \$ _____ <input type="checkbox"/> You are responsible for a coinsurance of _____ percent <input type="checkbox"/> We require a payment of \$ _____ towards that coins. per visit <input type="checkbox"/> Your total out of pocket is \$ _____ <input type="checkbox"/> You have met \$ _____ of your total out of pocket expenses |
|---|--|
- Your insurance allows \$ _____ for therapy each benefit year. We estimate that to be _____ visits. This does **not** guarantee this number of visits, but this is an estimate to assist you in making decisions regarding your therapy.
 - Your benefits allow you _____ PT/OT visits each benefit year.
 - Your insurance requires precertification and has authorized _____ visits. Precertification Expires on _____
 - Your benefits are pending because: _____

I have read the information above and understand that I am responsible for payment of therapy services not covered by my insurance policy.

X _____
Patient / Guardian Signature

Date



proaxistherapy™
INNOVATIVE THERAPY RESOURCE

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost in professionalism and service excellence. Our commitment to your well being and improvement in your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require 48 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In instances of repeated cancellations without 48 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a \$25 fee as allowed by insurance contracts.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Proaxis Therapy

*I have read and understand this policy:*_____ *Date:*_____



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.

PLEASE REVIEW IT CAREFULLY.

Your health information is personal, and we are committed to protecting it. Your health information is also very important to our ability to provide you with quality care, and to comply with certain laws. This Notice applies to all records about your care that occurs at any of our proaxistherapy facilities. This Notice applies to all records about your care at our facilities or affiliated entities.

HIPAA does not apply to information disclosed in connection with a worker's compensation matter. Pursuant to law, your health information relevant to a worker's compensation matter will be disclosed to your employer's workers compensation insurer or third party administrator and to your employer.

I. We Are Legally Required to Safeguard Your Protected Health Information. We are required by law to:

- A. maintain the privacy of your health information, also known as "protected health information" or "PHI;"
- B. provide you with this Notice, and
- C. comply with this Notice.

II. Future Changes to Our Practices and This Notice. We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting the Privacy Officer at 125 The Parkway, Suite 501, Greenville, SC 29615. We will also make any revised Notice available in our clinics.

III. How We May Use and Disclose Your Protected Health Information. The law requires us to have your written authorization to some uses and disclosures. In other circumstances, the law allows us to use or disclose PHI without your written authorization. This Section gives examples of each of these circumstances.

A. Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use or disclose your PHI to provide treatment to you. For example, we may disclose your PHI to physicians, nurses, and other health care personnel who are involved in your care. We may also use and disclose your PHI to contact you as a reminder that you have an appointment for treatment at our facility, to tell you about or recommend possible treatment options or alternatives, or about health-related benefits or services that may interest you.

We may also use or disclose your PHI to your insurance carrier in order to get paid for treatment provided to you. For example, we may use your PHI to create the bills that we submit to the insurance company, or we may disclose certain portions of your PHI to our business associates who perform billing and claims processing services to us.

We may also use or disclose your PHI in order to operate this facility. For example, we may use your PHI to evaluate the quality of care you received from us, or to evaluate the performance of those involved with your care. We may also provide your PHI to our attorneys, accountants and other consultants to make sure we are complying with the laws that affect us.

B. Uses and Disclosures That Require Us to Give You the Opportunity to Object. If you do not object, we may include your name and location in our facility in the patient directory that we use when responding to requests by those who ask for you by name. Unless you object, we may provide relevant portions of your PHI to a family member, friend or other person you indicate is involved in your health care or in helping you get payment for your health care. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it later, after the emergency, and give you the opportunity to object to future disclosures to family and friends. Unless you object, we may also disclose your PHI to persons performing disaster relief notification activities.

C. Certain Uses and Disclosures Do Not Require Your Written Authorization Other than Uses and Disclosures for Treatment, Payment and Health Care Operations. The law allows us to disclose PHI without your written authorization in the following circumstances:

- (1) When Required by Law. We disclose PHI when we are required to do so by federal, state or local law.
- (2) For Public Health Activities. For example, we disclose PHI when we report suspected child abuse, the occurrence of certain diseases, or adverse reactions to a drug or medical device.
- (3) For Reports About Victims of Abuse, Neglect or Domestic Violence. We will disclose your PHI in these reports only if we are required or authorized by law to do so, or if you otherwise agree.
- (4) To Health Oversight Agencies. We will provide PHI as requested to government agencies that have authority to audit or investigate our operations.
- (5) For Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or to obtain a court order that will protect the PHI requested.
- (6) To Law Enforcement. We may release PHI if asked to do so by a law enforcement official, in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be due to criminal conduct; (e) about criminal conduct at our facility; and (f) in emergency circumstances, to report a crime, its location or victims, or the identity, description or location of the person who committed the crime.
- (9) For Medical Research. We may disclose your PHI without your written authorization to medical researchers who request it for approved medical research projects; however, with very limited exceptions such disclosures must be cleared through a special approval process before any PHI is disclosed to the researchers, who will be required to safeguard the PHI they receive.
- (10) To Avert a Serious Threat to Health or Safety. We may disclose your PHI to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the public.

(11) For Specialized Government Functions. For example, we may disclose your PHI to authorized federal officials for intelligence and national security activities that are authorized by law, or so that they may provide protective services to the President or foreign heads of state or conduct special investigations authorized by law.

(12) To Workers' Compensation or Similar Programs. We may provide your PHI to these programs in order for you to obtain benefits for work-related injuries or illness.

For some types of PHI, there may be stricter restrictions on our use or disclosure of PHI. For example, drug and alcohol abuse patient treatment information, HIV test results, mental health information, and genetic testing results may be subject to greater protection of your privacy.

In general, we may disclose a minor patient's PHI to a parent or guardian, but we may deny the parents' access to the minor patient's PHI in some situations.

IV. Other Uses and Disclosures of Your Protected Health Information. Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclosure your PHI for the purposes specified in the written authorization, except that we are unable to take back any disclosures we have already made with your permission, and are required to retain certain records of the uses and disclosures made when the authorization was in effect.

V. Your Rights Related to Your Protected Health Information. You have the following rights:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit how we use and disclose your PHI, as long as you are not asking us to limit uses and disclosures that we are required or authorized to make to the Secretary of the federal Department of Health Services, related to our facility's patient directory, or any of the disclosures described in Section III, above. Any such request must be submitted in writing to our Privacy Officer. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment.

B. The Right to Choose How We Communicate With You. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). We must agree to your request as long as it would not be disruptive to our operations to do so. You must make any such request in writing, addressed to our Privacy Officer.

C. The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and copy your PHI if you ask in writing to do so. Any such request must be addressed to our Medical Records Department, which will respond to your request within 30 days (or 60 days if the extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your right to have the denial reviewed.

If you ask us to copy your PHI, we will charge you \$15.00 processing fee and \$.65 per page

D. The Right to Correct or Update Your PHI. If you believe that the PHI we have about you is incomplete or incorrect, you may ask us to amend it. Any such request must be made in writing and must be addressed to our Medical Records Department, and must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask you who else you would like us to notify of the amendment.

We may deny your request if you ask us to amend information that:

- (1) was not created by us, unless the person who created the information is no longer available to make the amendment;
- (2) is not part of the PHI we keep about you;
- (3) is not part of the PHI that you would be allowed to see or copy; or
- (4) is determined by us to be accurate and complete.

If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint, or to request inclusion of your original amendment request in your PHI.

E. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include disclosures we have made for our treatment, payment and health care operations purposes, those made directly to you or your family or friends or through our facility directory, or for disaster notification purposes. Neither will the list include disclosures we have made with your written authorization, for national security purposes or to law enforcement personnel, disclosure of limited data set, or disclosures made before April 14, 2003.

Your request for a list of disclosures must be made in writing and be addressed to our Medical Records Department. We will respond to your request within 60 days (or 90 days if the extra time is needed). The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period.

F. The Right to Get a Paper Copy of This Notice. Even if you have agreed to receive the Notice by e-mail, you have the right to request a paper copy as well. You may obtain a paper copy of this Notice by contacting the Privacy Officer at 125 The Parkway, Suite 501, Greenville, SC 29615. The Notice is also available in our clinics.

VI. Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the federal Department of Health and Human Services. To file a complaint with us, put your complaint in writing and address it to our Privacy Officer. We will not retaliate against you for filing a complaint. You may also contact our Privacy Officer if you have questions or comments about our privacy practices.