

FITNESS QUEST

New Patient Information

Name: _____ Date: _____
Address: _____ Home Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip: _____ Work Phone: _____
Emergency Contact: _____ Emergency Phone Number: _____
Referring Physician: _____ GP, if not referring MD: _____
Date of Birth: _____ Sex: M / F Marital Status: _____
Social Security #: _____ - _____ - _____ Email Address: _____
Occupation: Employed Unemployed Retired Student

If employed, type of employment: _____

How did you hear about Fitness Quest? (Circle) Doctor Friend/Family (Who?: _____) Other: _____

Consent to Treatment:

I am entering a Physical Therapist/Patient Relationship today and am consenting to allowing the physical therapist to obtain information throughout questioning, the laying of hands-on by way of physical exam, and performing special tests, to arrive at a plan of care to treat the problem I am seeking medical attention for today. I understand that as a competent adult I do not have to accept anything that my physical therapist instructs me on even if there may be grave bodily injury to myself if I should forego his/her recommendations. I also understand that if I refuse treatment or am consistently non-compliant with his/her recommendations, that the physical therapist, who must try, under ethical terms, to provide beneficence and non-maleficence to his/her patients may elect to end the Physical Therapist/Patient Relationship that has been established. The physical therapist will provide me with a list of alternative physical therapists that can provide my continued care. I also understand that I may at any time end this relationship with my physical therapist.

INITIALS

Allowance of Third Party Insurers to Pay Providers Directly

By initialing below, I agree that all payments regarding the delivery of services by a Fitness Quest employee, be paid directly to Fitness Quest, at its business address. This will remain in effect until revoked by me (patient) in writing. I understand that I am responsible for all charges whether or not paid by said insurance. I further understand and agree that if Fitness Quest must take action to collect any outstanding balance on my account, I will be responsible for payment of and will reimburse Fitness Quest for all costs such as collection efforts, including but not limited to all court costs and attorney fees. All unpaid account balances will be considered delinquent sixty (60) days from the date of the charge. At the time of the visit, the appropriate insurance co-payment is due in full, if applicable. Interest may be assessed on all delinquent accounts at a monthly rate of 1.5%.

INITIALS

Cancellation Policy

In order for you to get the most out of your physical therapy, please honor that a twelve hour notice must be given prior to a cancellation of an appointment. If you fail to give proper notice there will be a late cancellation fee of \$25.00. This also applies to patients who fail to show up for a scheduled appointment.

INITIALS

Blue Cross Blue Shield Patients Only

Occasionally BCBS will send payment and explanation of benefits directly to the patient. As your provider of services, it is vital that we receive this information so we can make the proper adjustments to your account. Therefore, it is your responsibility to bring or mail all checks and correspondence you receive from BCBS to Fitness Quest.

If you do not, you will receive a bill for the full unadjusted amount.

INITIALS



Patient Medical History

Your medical history is very important information for us to ensure your safety during your rehabilitation process. Please be as complete and honest as possible with your answers, and feel free to discuss your history with your therapists.

Please inform us if you have had a history of the following (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bowel/Bladder Dysfunction |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Hepatitis/ Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Polio | <input type="checkbox"/> Low Blood Sugar |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Hard of hearing |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Ringing in Ears | |

Have you recently experienced any of the following? (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Persistent pain at night | <input type="checkbox"/> Fever or Night Sweats | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Frequent Nausea or Vomiting | <input type="checkbox"/> Recent Weight Loss/Gain |
| <input type="checkbox"/> Frequent or Severe Abdominal Pain | <input type="checkbox"/> Significant change or loss of control of bowel/bladder | |

Please list *and* give dates of any significant surgeries you have had in the past 5 years:

Medications (please list all information for each, if you do not know please bring information next visit):

Name	Dosage	Frequency	Route of Administration
			ORAL OTHER:
			ORAL OTHER:
			ORAL OTHER:
			ORAL OTHER:
			ORAL OTHER:
			ORAL OTHER:

Body Mass Index:

Height: _____ Weight: _____

Falls:

Have you fallen in the past 12 months? Yes No Number of Falls: _____

If you answered YES to the above question, did you sustain an injury from your fall?

Please explain: _____

1. Are you (*circle one*): **Right-handed** **Left-handed**
2. Are you currently receiving any Home Health Services, or have you recently received Home Health Services for any condition? (i.e. Home Health Aide/Nurse/Therapy)? **YES/NO**
3. Have you had any form of therapy this year, for ANY condition? **YES/NO** If yes, when? _____
4. If your injury is the result of an Automobile accident or a Worker's Compensation claim please complete the following: **Date of Accident/Injury** _____ **State** _____ **Claim #** _____

*****Current Health Status (please circle yes or no):**

5. Do you smoke? **YES/NO**
6. Do you drink more than one alcoholic beverage per day? **YES/ NO**
7. Do you exercise regularly? **YES/ NO**
8. On average, how many days per week do you exercise? _____ For how long? _____ Type of exercise? _____
9. Leisure Activities/Hobbies _____
10. Are you pregnant? **YES/NO**
11. During the past month have you been feeling down, depressed or hopeless? **YES/NO**
12. Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES/NO**

Current Condition

Describe the main problem for which you seek physical therapy services?

When did the problem begin? (Approximate date): _____

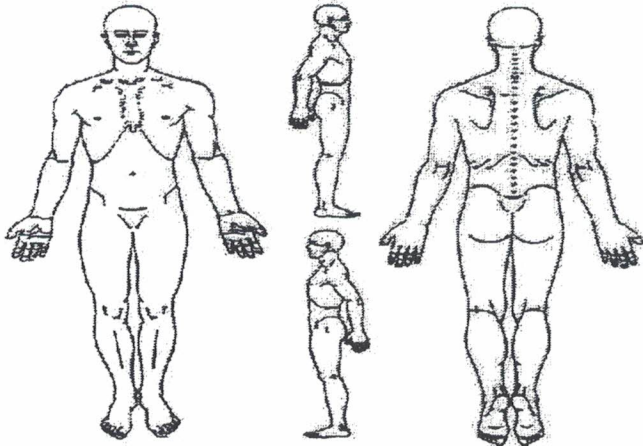
Please Mark Appropriately:

- X (Pain) ///-Stabbing
 O (Numbness/Tingling) □-Throbbing

Pain Level:

Please circle your pain level from 0-10 (0 indicates NO pain, while 10 indicates the need for a visit to the emergency room), indicate one number for pain at its worst and best:

0 1 2 3 4 5 6 7 8 9 10



Please check any of the following tests you have had for this problem:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Blood Tests | <input type="checkbox"/> GI Tract Testing |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> EMG | <input type="checkbox"/> EKG |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Urine Culture | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Urodynamic Testing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dexa Scan | <input type="checkbox"/> Laparoscope | <input type="checkbox"/> Other: _____ |

Patient Signature

Date

I certify the above information is true to the best of my knowledge; I will notify you immediately of any changes to my status or information listed above.

Summary of Notice of HIPAA Privacy Practices

This summary notice of privacy practices serves to inform you how Fitness Quest and may use and disclose your protected health information (PHI). Fitness Quest creates and maintains a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to protect the health information that identifies you and to inform you of our legal duties and privacy practices.

Uses and Disclosures of Protected Health Information (PHI) by Patient Consent

- **Treatment:** We may use PHI to provide you with health care treatment or services. This includes but is not limited to discussions with referring physicians to plan care and treatment.
- **Payment:** We may use and disclose PHI to third party or insurance company to obtain benefit information and prior approval for treatment or to justify medical care.
- **Health Care Operations:** We may use and disclose PHI to ensure that you are receiving the highest quality of care possible.

Uses and Disclosures of Protected Health Information (PHI) as required by Law

We will disclose PHI about you when required to do so by federal, state, or local law. Such examples are:

- To avert a serious threat to health or safety
- For military personnel or veterans to Dept. of Veterans Affairs
- Supply information regarding Worker's Compensation claims to insurance companies, case managers, or employers
- Public health risks
- In response to a subpoena, court order, or other lawful request
- Health Oversight Agency for activities authorized by law (audits, investigations, etc.)
- Law Enforcement requests
- Coroners or Health Examiners
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Your Rights as a Patient to your Protected Health Information (PHI)

You have the following rights:

- To inspect and copy your medical records
- To request an amendment to your medical records although Fitness Quest and BAPT are not required by law to change your records
- To request an accounting of the disclosures that Fitness Quest has made
- To request restrictions or limitations on your PHI
- To request confidential communications
- To obtain a copy of this notice at any time

*For all requests, please note that Fitness Quest has 30 days to respond to your request and has the right to charge you copying fees.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary or the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer at 941-900-1811. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Changes to this Notice

Fitness Quest reserves the right to change this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as information we receive in the future.

Consent to Use and Disclose Protected Health Information (PHI)

By signing this document, I agree to truthfully, completely, and correctly provide all requested information to Fitness Quest. Additionally, I am giving consent to Fitness Quest to use and disclose my protected health information for treatment, payment and health care operations.

Patient Name (PRINTED): _____

Signature of Patient, Guardian, or POA: _____ Date: _____

Fitness Quest

Acknowledgement of Receipt of Patient's Right to Report Complaints, Abuse
Pursuant to Florida Regulation 408.810(5), patients must be informed of their right to report complaints or abuse to the Agency for Healthcare Administration via a statewide, toll-free number.

Complaints: To report a complaint regarding the services you receive, please call toll-free: 888-419-3456.

Abuse: To report abuse, neglect or exploitation, please call toll-free: 800-96-ABUSE.

By signing below, I acknowledge that I have received information regarding the Patient's Right to Report Complaints and Abuse.

Date: _____