



Personally Fit
FITNESS & PHYSICAL THERAPY

11501 Rancho Bernardo Road, Suite #100 San Diego, CA 92127 858-485-6706 Fax 858-485-7052

Date _____ Referring Doctor _____

Patient Information

Last Name _____ First _____ M.I. _____

Address _____ Apt. Number _____

City _____ State _____ Zip _____ Home Phone () _____

Work Ph () _____ Cell Ph. () _____ Email Address _____

SS # _____ Date of Birth _____ Sex M ___ F ___

Drivers License # _____ Marital Status M ___ S ___ D ___

Spouse's Name _____

Is this a work related injury? Yes ___ No ___ Date of Injury _____

Is this an auto accident related injury? Yes ___ No ___

Is there an attorney involved? Yes ___ No ___

Patient Work Information

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip _____

Work Ph () _____ Extension _____ Employee ID _____

Medicare Information

Medicare Number (if applicable): _____

Private Insurance Information

Are you the policy holder? Yes ___ No ___ If no who is the policy holder?

Last Name _____ First _____ M.I. _____

Your relationship to the insured? _____ Policy Number _____

Group Number _____ Certificate Number _____

Insurance Company Name _____

Address _____

City _____ State _____ Zip _____ Phone No. _____



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Consent for Care and Treatment

The undersigned agrees and gives consent for Personally Fit, Inc to furnish physical therapy services which are considered necessary and proper in assessing and treating his/her physical condition.

Financial Agreement

The undersigned agrees, whether he/she signs as patient or agent of a patient, that in consideration of the services to be provided to the patient, he/she individually obligates himself/herself to pay the account of the patient. The signature below indicates responsibility for payment due to change in insurance or if insurance is terminated.

Medicare Patients

Medicare Authorization (for signature on file): The undersigned authorizes the release of any medical information necessary to process this claim. The undersigned also requests payment of government benefits to the party who accepts assignment (Personally Fit, Inc.).

HIPPA Guidelines

The undersigned has received and understands rights according to the Health Information Privacy and Accountability Act (HIPAA).

Cancellation Policy

The undersigned agrees to provide at least 12 hour notice of cancellation of an appointment. He/She agrees to pay a \$25.00 "late cancellation" fee if this notification is not provided. Personally Fit, Inc. may provide a courtesy reminder call on the date prior to an appointment. Failure to receive a reminder call does not negate patients' responsibility.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Relationship in not Patient's signature: _____

Deductible amount: _____

Co-pay Amount: _____



Patient's Name _____

Is this an injury or accident case? Yes No If yes, is there an attorney involved? Yes No

Are you currently taking any prescription or non-prescription medications? Yes No
(Includes vitamins, supplements, and over the counter medication)

If yes, please list your medications and the dosages:

Medications	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

- | | | | |
|------------------------------------|--|--------------------------------|--|
| Asthma, Bronchitis, or Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe or Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coronary Heart Disease of Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision or Hearing Difficulties | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of Breath / Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness or Tingling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness or Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack or Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel or Bladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke / TIA | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congestive Heart Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Clot / Emboli | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss / Energy Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy / Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pins or Metal Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Infectious Diseases | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Injury / Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer of Chemo / Radiation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shoulder Injury / Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Elbow / Hand Injury / Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Knee Injury / Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sleeping Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Injury / Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ankle / Foot Injury / Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emotional / Psychological Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are You Pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do You Have a Pacemaker? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do You Use Tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

List any other information that you feel would assist us in your care: _____

Have you experienced any falls over the past year? Yes No
If yes, approximately how many? _____ Any injury? Yes No

Patient / Guardian Signature _____ Date _____
Physical Therapist Signature _____ Date _____

Personally Fit, Inc
11501 Rancho Bernardo Road, Ste. 100
San Diego, CA 92127
858-485-6706

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.

We understand that your health information is personal, including your physical therapy records. At Personally Fit, we promise to make every effort to keep your medical information private. We make a record of the physical therapy services that we provide to you. Sometimes we receive records about you from other providers, like your physician. We use these records to:

- Provide you with quality health care
- Enable other health care providers to give you care
- Obtain payment for services as allowed by your health plan
- Meet your professional and legal obligations.

We are required by law to keep your protected health information private. We are required by law to provide you with a notice, such as this one, describing our legal duties and our privacy practices regarding your protected health information, and we are required to comply with the notice we provide. This notice describes how we may use and disclose your medical information. This also describes your rights and our legal responsibilities in regard to your medical information. If you have any questions about this notice, please don't hesitate to ask.

Part One: How Personally Fit May Use or Disclose Your Health Information

Personally Fit collects health information about you and maintains it in a chart and on a computer. This is your medical record. The medical record is the property of Personally Fit, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purpose:

1. **Treatment.** We use your medical information to provide you with physical therapy. We disclose medical information to our employees. We disclose medical information to others who are involved in providing you care (like your physician).
2. **Payment.** We use and disclose medical information about you to obtain payment for our services. For example, we give your health plan the information it requires before it will pay us. Personally Fit utilizes a billing service to collect for the services that we provide. We are required to provide them with your billing information. We also may disclose information to someone who is involved in paying for or arranging for payment for your care. If you fail to pay for the medical services that we provide, we may disclose your information to a collection agency to assist us in obtaining payment.
3. **Operations.** We may use and disclose medical information to operate our facility. For example, we may use and disclose this information to:
 - Review and improve the quality of care that we provide
 - Review and improve the competence and qualifications of our therapy staff
 - Obtain authorization for services or referrals from your physician or health plan
 - Take part in medical reviews
 - Take part in legal services and audits, including fraud and abuse detection, and
 - Take part in compliance programs, business planning and management activities.

We did not create the information (unless the person or entity is no longer available to make the amendment)
We determine in our sole discretion that the information is accurate and complete as is.

5. **Right to accounting of disclosures:** You have a right to receive an accounting of disclosures of your health information made by Personally Fit. Personally Fit does not have to account for disclosures:
 - Provided to you
 - Provided to others by your written authorization
 - In facility directories
 - To relatives or caretakers involved in your care
 - For notification purposes in disaster and other situations
 - To correctional institutions or law enforcement officials as required or allowed by law
 - As described in Part one of this notice
 - That occurred prior to April 14, 2003

6. **Paper copy:** You have a right to a paper copy of this Notice of Privacy Practices.

Part four: Changes in this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current Notice posted. A copy will be available at each appointment, if requested.

Part five: Complaints about this Notice of Privacy Practices or about how Personally Fit handles your health information should be directed to our Compliance Officer, James R. Flood, MS PT. Mr. Flood can be reached at 858-485-6706 or by email at jflood@personallyfitonline.com

We may also share your medical information with our "business associates". An example would be our billing company that performs services for us. We have a written contract with them. This contract requires them to protect the privacy of your medical information.

4. **Appointment Reminders.** We may use and disclose medical information to contact you about your appointments. If you are not at home, we may leave information about your appointment on your answering machine. If you are not at home, we may leave a message with the person answering the phone. We will not disclose information about your specific medical condition or the purpose of your appointment at Personally Fit in a voicemail message or with any individual other than you.
5. **Sign in sheet:** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to serve you. We will not require that you state the purpose of your visit or your medical condition on the sign-in sheet.

6. **Required by law:** We will use and disclose your health information as required by law. We will limit our use or disclosure to the relevant requirements of the law. For example, we may use and disclose your information when necessary to:
 - Report abuse
 - Report neglect
 - Report domestic violence
 - Respond to judicial or administrative proceedings, or
 - Respond to law enforcement officials.

7. **Public Health:** We may disclose your health information to public authorities. The reason for the disclosure may include the following:
 - Preventing or controlling disease, injury, or disability
 - Reporting child, elder, or dependent adult neglect
 - Reporting disease or infection exposure.

8. **Health Oversight Activities:** We may disclose your health information to health oversight agencies. This disclosure could occur during the course of:

- Audits
- Investigations
- Inspections
- Licensure, and
- Other proceedings.

This disclosure is subject to the limitations imposed by Federal and California law.

9. **Judicial and Administrative Proceedings:** We may disclose your health information in the course of any administrative or judicial proceeding. We will only disclose your information to the extent authorized by a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process. In this case, we will only disclose your health information if reasonable efforts have been made to notify you of the request, and you have not objected. If you have objected, we will only disclose your information if your objections have been resolved by a court or administrative order.

10. **Law Enforcement:** We may disclose your health information to law enforcement officials. The purposes for such a disclosure include:
 - Identifying or locating a suspect, fugitive, material witness, or missing person
 - Complying with a court order, warrant, grand jury subpoena, and
 - Complying with other law enforcement purposes.

11. **Public Safety:** We may disclose your health information to the appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

12. **Specialized Government Purposes:** We may disclose your health information for military or national security purposes. We may disclose your health information to correctional institutions or law enforcement officers that have you in their lawful custody.

13. **Worker's Compensation:** We may disclose your health information to comply with worker's compensation laws. For example, to the extent your care is covered by worker's compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational illness to the employer or worker's compensation insurer.

Part two: When Personally Fit may not use or disclose your health information

Except as described in this notice of privacy practices, Personally Fit will not use or disclose health information which identifies you without your written authorization. If you do authorize Personally Fit to use and disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Part three: Your health information rights

As a patient at Personally Fit, you have the following rights:

1. **Right to request special privacy protections:** You have the right to request restrictions on certain uses and disclosures of your health information. You can do this by written request. You need to specify what limitations on our use of the information you wish to have in place. We reserve the right to accept or reject your request, and will notify you of our decision.
2. **Right to request confidential communications:** You have the right to request that you receive your health information in a certain way or at a certain location. We will comply with all reasonable requests submitted in writing. You need to specify how and where you wish to receive these communications.
3. **Right to request and copy:** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request. The request must detail what information you want to access and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
4. **Right to amend or supplement:** You have the right to request that we amend your health information, should you believe it to be incorrect or incomplete. You must make a request to amend in writing. Your statement of amendment may be up to 250 words. The request must include reasons you believe the information is inaccurate or incomplete. We may deny your request if:
 - We do not have the information