ReNew: Concierge Physical Therapy

www.RenewPensacolaPT.com

Phone Number: 850-332-3834

Fax Number: 850-378-4522

Informed Consent

I, ________________________________ understand that I will be participating in private, one-on-one physical therapy, incorporating hands-on treatment, manual passive stretching, spinal mobilization, kinesiotaping, myofascial release, and traditional conservative treatment techniques so that I can improve my strength, endurance, flexibility, balance, core strength, and overall health and wellness.

I understand that my physical therapist is licensed in the State of Florida, and is educated and highly-trained in the areas above.

By signing below, I am giving my consent to treatment ("informed consent"). And, I also consent for treatment to occur in my home, gym, workplace, hotel room, or other location previously agreed upon.

I have been instructed by my physical therapist to alert my therapist of any special needs, injuries, preferences, or considerations prior to starting the first visit evaluation and treatment, as these could affect my safety and security during the treatment process.

I understand that by signing below, I release this physical therapist of all liabilities for my health and safety during my participation in this treatment process.

I only provide this release with the understanding that my instructor is fully trained and upholds an active license to perform physical therapy in the State of Florida.

I understand that it is my responsibility to verbally notify my physical therapist if at any time I become uncomfortable with a treatment option, treatment position or hand placement. Once verbal notification is given to cease any treatment, position or hand placement, all treatment will stop immediately before continuing based on the patient's instruction.

Print Name: ____ Date:_______________________

Signature: ____ Date of Birth: _______________

Address: ____

City, State: ____ Zip: ________________________

Phone: ____

Email (print clearly): ____

FEDERAL HIPAA NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

ReNew: Concierge Physical Therapy, LLC

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: refers to ReNew: Concierge Physical Therapy, LLC. "You" or "yours" refers to any individual receiving treatment by ReNew: Concierge Physical Therapy, LLC employees.

Federal law - means the Health Insurance Portability and Accountability Act and related privacy rules -- requires ReNew: Concierge Physical Therapy, LLC to keep your health information private. We are not allowed to use or disclose it unless we receive your permission or unless permitted by law. Federal law requires us to give you this Notice of our legal duties and privacy practices. This Notice is to inform you of uses and disclosures of your health information that we may make. It also informs you of your rights and our duties with regard to this health information.

We must follow the terms of this Notice. We do reserve the right to change the terms of this Notice and make the new Notice provisions apply to all the health information we keep. This includes health information we had prior to any change in this Notice. We must promptly change this Notice when there is a material change to our uses or disclosures, your rights, our duties and other related circumstances. To receive such Notices by email, you should tell the contact listed at the end of this Notice.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Federal law permits us to use and disclose protected health information for purposes of treatment, payment and health care operations as those terms are defined under federal law. We will comply with any state or federal law that is more restrictive as to our uses and disclosures of protected health information.

There are also times when federal law permits or requires us to use or disclose your information without your written permission. Additionally, where appropriate, we may disclose protected health information to a group health plan or plan sponsor in accordance with federal law.

Permitted Disclosures:
We may not make all of the uses and disclosures listed here, but federal law permits use or disclosure of your information without your permission

- When we disclose your information to you.
- To third party non – ReNew: Concierge Physical Therapy, LLC associates that perform services for us or on our behalf.
- Where disclosure is required by law.
- To a public health authority authorized by law to collect or receive your information to prevent or control disease, injury or disability or when reviewing reports of child abuse or for the conduct of other authorized public health activities and responsibilities.
- To a health oversight agency for such activities.
- For judicial and administrative proceedings.
- To a law enforcement official for a law enforcement purpose.
- To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law.
- To organ donor organizations in order to aid in such donations.
- For certain research purposes authorized by and subject to federal law.
- To avert a serious threat to health or safety.
- To government officials regarding military personnel and certain domestic and foreign government officials for certain functions authorized by federal law.
- To comply with workers' compensation and other similar programs.

Required Disclosures
We must disclose your information when required by the Secretary of the Department of Health and Human Services to make sure we comply with federal law.
We are also required, with certain exceptions, to provide you with access to inspect and obtain a copy of your information that we keep. See "Federal Law Provides You with the Right to Inspect and Copy Protected Health Information" below.

INDIVIDUAL RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS: You have the right to request that restrictions be placed on certain uses and disclosures of your information. We are not required to agree. If we do agree, we may not use or disclose any of your information except where you need emergency treatment. We may end an agreement to restrict as allowed by federal law. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION: If you choose to have your information sent to you by a means of your choice or to an address of your choice, we will do so if the request is reasonable. You must clearly state that disclosure of all or any part of your information could endanger you if not sent per your choice. Any such request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED INFORMATION: You have the right to inspect and copy your information, certain information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure. Any request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right, even if you have agreed to receive notice by email, to get a paper copy of this Notice. All requests should be in writing and sent to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT. If you believe your privacy rights have been violated, you have the right to complain to us by writing to the contact listed at the end of this Notice. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is also available to provide you information regarding questions you have or other information concerning this Notice.

THE CONTACT TO WHOM YOU SHOULD ADDRESS YOUR COMPLAINT IS:

ReNew: Concierge Physical Therapy, LLC
Dr. David Harvitz, DPT – License Number: PT33079

Telephone Number: 850-332-3834

The effective date of this notice is 1/1/2020.

HIPAA COMPLIANCE: I understand that ReNew: Concierge Physical Therapy, LLC may use or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ReNew: Concierge Physical Therapy, LLC will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my PHI for purposes as noted in ReNew: Concierge Physical Therapy, LLC Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name____

Signature:____________________________________ Date:_________________

Payment Agreement

Thank you for choosing Renew Concierge Physical Therapy as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and we are not equipped to do Medicare billing. If you want Medicare to pay for any of your services that might be considered covered benefits, you should seek services from another Medicare enrolled provider. By choosing to receive our services after being fully informed of these facts, you are exercising your privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) and restricting disclosure of your records and claims to Medicare. This means we will not submit any claims to Medicare on your behalf or provide you with a receipt or bill that you can submit to Medicare yourself and Medicare will not reimburse you for our services even if your services would have been covered if provided by another Medicare enrolled provider. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare Advantage Plans ("MAP").** We are not in-network with any Medicare Advantage Plans. If your MAP offers out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your MAP for reimbursement for the services your health plan covers. However, you should be prepared that your MAP may have pre-authorization requirements that must be met before out-of-network services are paid. You are responsible for contacting your MAP to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your MAP denies, in whole or in part, your claims for our services.

  - **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we do not accept Medicare at this location, you agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement of copays, coinsurance or deductibles that your commercial health plan does not pay.
- **Wellness & Fitness Services.** Most commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other visits.
  - **Use of Health Savings Accounts (HSA).** If you purchase a pre-paid package plan through your HSA account, we will give you a receipt for the pre-paid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.
  - **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.
- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are

exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **Service Termination Policy.** If we determine at any time that conditions in your home create a potentially unsafe environment for our providers, we may, at our sole discretion, terminate our services with you. If we do so, we will make reasonable efforts to refer you to the services you need to resolve the issue that is causing a potentially unsafe environment. If you have prepaid for any services, we will refund any monies paid for services not yet received as of the date or our termination.

No Show and Cancelation Policy

A high priority of ReNew: Concierge Physical Therapy, LLC to provide the most convenient care possible for all patients. This goal is only obtained with the help of all participating patients/clients. For this reason, a “No Show” and “Cancellation” has been implemented. Please be courteous and call ahead to cancel any appointments 24 hours in advance. A waiting list of patients is common at this time and 24 hours allows for that time to be reallocated to someone in need of that appointment time.

- Cancellation: Patients that fail to cancel their appointment within 24 hours of their scheduled appointment time will receive a reminder and grace with no fee. On the second occurrence, the patient/client will be subject to a $25 fee. On the third occurrence, the patient/client will be subject to a $45 fee. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time grace exception may be granted at the discretion of ReNew: Concierge Physical Therapy, LLC.
- No Show: Patients that fail to be present for their scheduled appointment time at their predetermined location, with no prior contact or attempt to cancel their appointment will be responsible for 50% of the cost for that visit on the first occurrence and responsible for 100% of the associated cost for their second occurrence. A third occurrence will result in another fee equal to the cost of the scheduled visit and discharge from PT services.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

Patient Name (Print or Type):

____

X ____ Date: ______________________

Patient’s Signature

A photocopy of this agreement is to be considered valid, the same as if it was the original.

Patient Intake Questionnaire

Patient Demographics

Last Name: ________________________________ First Name: _________________________

Sex: ________ Date of Birth: _________________

Primary Physician: _____________________________________ Phone: __________________

Marital Status:
Single______ Married ______ Divorced ______ Widowed _______ Domestic Partner _______

Injury: Work or Auto related? _________ Allergies or Medical Precautions: ________________

Emergency Contact: __________________________________ Phone#: ___________________

Insurance Company Name: ____

Current History
What is your Chief Complaint? (Example: pain, decreased motion, swelling/edema, stiffness)

____

____

Where is your problem? ____

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing ___Shooting ___Aching ___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing

When and how did this problem begin?____

What makes your symptoms/ pain worse?____

What makes your symptoms/ pain lessen?____

____

Rate your pain from 0-10 with 0 = no pain; 10 = emergency room: ________________________

When are your symptoms worst: ___Morning ___Afternoon ___Evening ____ Inconsistent____

Are your symptoms: ________Improving ________Worsening _________Stable___________

Medical History

Please answer the following questions:

	YES	NO
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (cane foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

Have you had past, similar episodes of this current problem? Circle: YES NO
If yes, were you treated with;(circle disciplines, which apply):

Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates,

General Exercise, exercise with trainer, Self-medicated (Advil), ignored it, other: ____________

Did they help to alleviate your symptoms?____

____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) – YES NO

If yes, do you know the results?____

____

Any other illness, past injuries I should be aware of?_____________________________________

____

Past surgeries – YES NO
If yes, please give brief details:____

____

List the medications you are currently taking (over the counter/prescription):________________

Social History
Are you presently working? ______Yes, ______No, since:________________________________

Overall activity level: ____Sedentary ____Light ____Mod ____Heavy ____Very heavy ____

Sports and Exercise (Type, Frequency, Duration) _______________________________________

____

Use of Tobacco ____Yes, ____no. Use of Alcohol ____Yes, ____No.

Family Medical History:
Does anyone in your immediate family (mother, father, siblings) have a history of Diabetes,

High Blood Pressure, Cardiac Problems, or Cancer?____________________________________

____

Please list 3 goals of Physical Therapy and time frames:

1)____

2)____

3)____

Who can we thank for this referral? ____