APPLE PHYSICAL THERAPY, LLC

Background Information & Medical History Form

To ensure you receive a complete and thorough evaluation, please provide us with information regarding your health status found on this form. If you do not understand a question, leave the area blank and your therapist will assist you. Thank you!

Name: _____ Date: _____

Are you currently: (check one)
- ☐ Working at your usual job with no restrictions.
- ☐ Working at your usual job with restrictions.
- ☐ Unable to work because of your condition since: _____
- ☐ Unable to work due to other medical reasons.
- ☐ Retired / Unemployed / Homemaker

Have you ever had physical therapy for this condition?

Circle: YES NO

Are you seeing:
☐ Medical Doctor ☐ Dentist ☐ Psychiatrist/Psychologist
☐ Osteopath ☐ Physical therapist ☐ Chiropractor

If you have seen any of the above during the last three months, please describe the reason (illness, medical conditions, injury, routine physical, etc.).

_____
_____
_____

Have you EVER been diagnosed as having any of the following conditions:

Yes No Heart Problems
Yes No High blood pressure
Yes No Stroke
Yes No Rheumatoid Arthritis
Yes No Other Arthritic Problems
Yes No Epilepsy
Yes No Lung Disease
Yes No Emphysema/Bronchitis
Yes No Asthma
Yes No Chemical Dependency
Yes No Hearing loss/disorder
Yes No Eye Disease
Yes No Muscle disease/disorder
Yes No Multiple Sclerosis
Yes No Diabetes
Yes No Tuberculosis
Yes No Hepatitis
Yes No Kidney Disease
Yes No Thyroid Problems
Yes No Depression
Yes No Circulation Problems
Yes No Osteoporosis
Yes No Cancer:
If yes, what kind: _____
Yes No Past Pregnancy:
Delivery (please circle): vaginal cesarean
Yes No Currently Pregnant? _____ months
Yes No Other: _____

Please list any surgeries or other conditions for which you have been hospitalized, including dates and reasons.

Date SURGERY REASON:

_____
_____
_____

Please describe any injuries for which you have been treated (fractures, dislocations, sprains/strains).

Date INJURY Date INJURY

_____
_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

Yes No Diabetes
Yes No Heart disease
Yes No Arthritis
Yes No High blood pressure
Yes No Epilepsy
Yes No Chemical dependency
Yes No Tuberculosis
Yes No Cancer
Yes No Headaches
Yes No Mental Illness

Which of the following OVER-THE-COUNTER medications have you taken in the past week?

Yes No Aspirin
Yes No Advil/Motrin/Ibuprofen
Yes No Tylenol
Yes No Decongestants
Yes No Antacids
Yes No Laxatives
Yes No Antihistamines
Yes No Vitamins/Mineral Supplements
Yes No Other: _____

List all PRESCRIPTION medicines you are currently taking (pills, injections, and skin patches):

_____
_____

Medicine Allergies: _____

How much caffeine per day? _____ Cigarettes smoked per day? _____ Days a week you drink alcohol? _____

Have you recently noted:

Yes No Weight loss/gain
Yes No Nausea/Vomiting
Yes No Fatigue
Yes No Weakness
Yes No Fever/Chills/Sweats
Yes No Numbness or tingling
Yes No Menstrual Irregularities
Yes No Bladder Irregularities
Yes No Rectal Bleeding

Form reviewed with patient: YES NO Therapist signature: _____

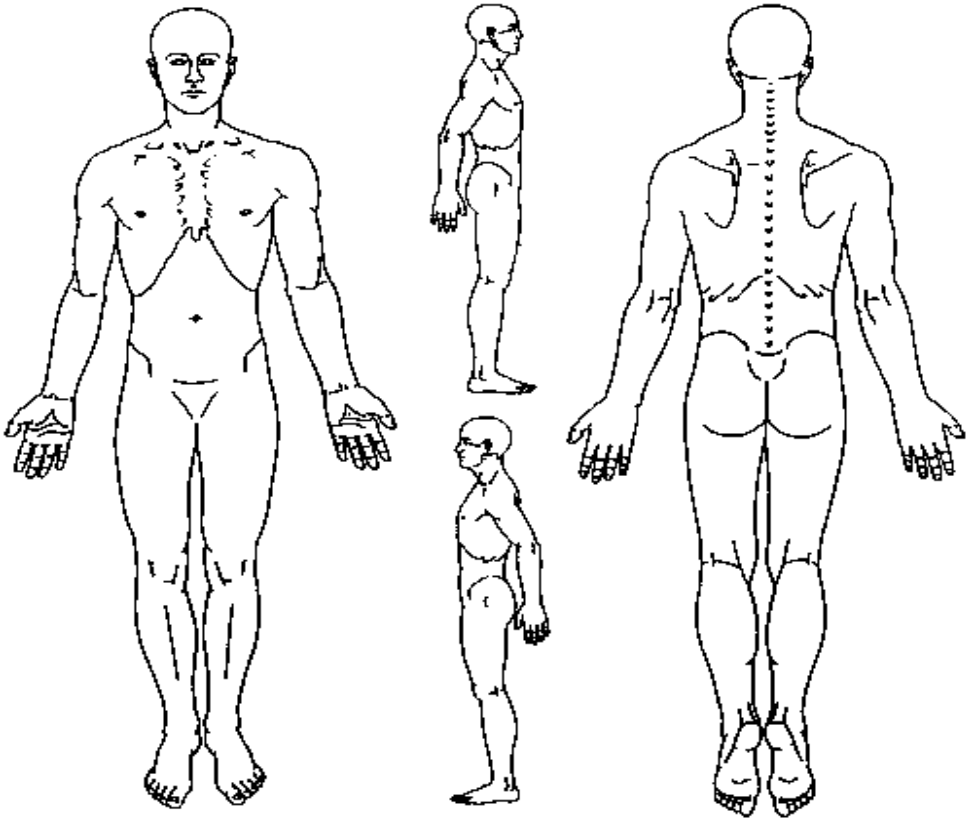
APPLE PHYSICAL THERAPY, LLC

SYMPTOM DIAGRAM

Patient's Name_____ Date_____

Use the following drawing to indicate the location of your symptoms at the present time.
Use the various symbols to describe the symptoms.

SHARP PAIN	ACHINESS	BURNING	PINS AND NEEDLES	NUMBNESS
////	XXX	!!!!	0000	++++



Instructions: Rate your major area of pain on the 0-10 Pain Rating Scale below:

0	1	2	3	4	5	6	7	8	9	10
No pain		Weak	Moderate		Strong		Very Strong		Maximal Pain	

Please rate your pain (0-10) at rest and with activity in the spaces provided:

With Activity_____ At Rest_____

APPLE PHYSICAL THERAPY CANCELLATION/NO SHOW POLICY

Apple Physical Therapy takes the subject of canceling your appointment very seriously, as it can make the difference as to whether you recover from your injury or condition. Showing up as scheduled is one of your most important responsibilities.

Apple Physical Therapy requires 24 hours notice for the cancellation of a scheduled appointment. Please have an alternative appointment time in mind for that week when you call to cancel. It is important that you receive your full amount of prescribed treatment since many insurance companies restrict physical therapy benefits. Your prescribed number of visits is determined by your physical therapist after your initial evaluation.

There is a $20 charge for a no-show or cancellation WITHOUT proper notice. This charge will NOT be covered by your insurance, but will have to be paid by you personally.

We take this policy seriously because when a patient misses an appointment, three people are adversely affected:

1.) You, the patient --for not receiving the treatment you need.
2.) Your therapist – as now he or she has an empty space in the schedule, since the time was reserved for you personally.
3.) Another patient – who could have had your appointment time to receive treatment.

Sometimes, you may feel you should not attend physical therapy for the following reasons

1.) You may continue to have pain or feel your pain is worsened. Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. It is important to come in if you are in pain because there are treatments available that can lessen those symptoms.

2.) You are experiencing less pain. This is also not a reason to cancel or fail to show for your scheduled treatment. That is the point in your treatment progression to begin correction of the underlying causes of your problem and educate you as to how to avoid re-injury in the future.

As you can see, neither of these reasons are legitimate reasons to not keep your scheduled appointment.

Please cooperate with us in this regard, and we will have you out of pain and feeling better soon. We are looking forward to working with you.

I consent to the above, as indicated by my signature below:

(print name)_____

(signature)_____ (Date)_____

APPLE PHYSICAL THERAPY, LLC

PATIENT AUTHORIZATION AND GUARANTEE

****IMPORTANT: PLEASE READ THIS CAREFULLY*****

RELEASE OF INFORMATION

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment by Apple Physical Therapy to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to APT for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

VALUABLES

I hereby understand that APT is not responsible for valuables and personal property brought to the facility.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of APT.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by APT, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together ,with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a copayment, co-insurance and/or deductible for which I am fully responsible for paying. Although APT will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify APT of any changes in my insurance coverage while receiving physical therapy.

MEDICARE

I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, _____, by signing this document, acknowledge my consent to the above:

(Print Name)

Signature_____ Date:_____

APPLE PHYSICAL THERAPY, LLC

NOTICE OF PROTECTED HEALTH INFORMATION 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

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45§ 160.101 et seq.(the "Privacy Regulations"), Apple Physical Therapy ("The Practice"), is required to protect the privacy of your individuality identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent**: Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

a. **Treatment:** We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physical therapist may disclose your health information when consulting with a physician regarding your medical condition.

b. **Payment:** We are permitted to use your health information for the purpose of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or another authorized entities involved in the payment of your medical bill and may include copies or portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis and the procedures and supplies used in your treatment.

c. **Health Care Operations**: We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures with Patient Authorization**: Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization, however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.
3. **Uses and Disclosures with Patient Opportunity to Verbally Agree or Object**: Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.
4. **Uses and Disclosures without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object**: Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

a**. Use and Disclosures Required by Law**: We will disclose your health information when required to do so by law.

b. **Public Health Activities:** We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

c. **Abuse and Neglect**: We may disclose your health information if we have reasonable belief of abuse, neglect or domestic violence.

d. **Regulatory Agencies**: We may disclose your health information to a health care oversight agency for activities authorized by law including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

e. **Judicial and Administrative Proceedings**: We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal requests.

g. **Coroners, Medical Examiners, Funeral Directors**: We may disclose your health information to coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

h. **Research**: Under certain circumstances, we may disclose your health information to researchers when their clinical research study had been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

i. **Threats to Health and Safety**: We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. **Military/Veterans**: If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**: We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**: We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services or nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.

m. **Appointment Reminders**: We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and disclosures**: In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Use and Disclosures to Business Associates**: With an acknowledgement or a proper authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of Business Associates include, but are not limited to consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

PATIENT RIGHTS

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1 . **Right to Request Restrictions on the Use and Disclosure of Your Health Information:** You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request. If however, we agree to the requested restrictions, it is binding on us.
2. **Right to Inspect and Copy your Health Information**: You have the right to inspect and copy your own health information upon request. however, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.
3. **Right to Verbally Object**: You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or health care operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.
4. **Right to Seek an Amendment of Your Health Information**: You have the right to request an amendment of your health information. If we disagree with the request amendment, we will permit you to include a statement in the record Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.
5. **Right to an Accounting of Disclosure of Your Health Information:** You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request, provided, however that we need not provide an accounting for any information disclosed prior to April 14, 2003. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy regulations, disclosures to persons involved in your care, or disclosures that occurred prior to the April 14, 2003 compliance deadline under the privacy Regulations . The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.
6. **Right to Confidential Communications**: You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.
7. **Right to Revoke Your Authorization**: You have the right to revoke a validly executated authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.
8. **Right to Receive Copy of this Notice**: You have the right to receive a copy of this notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at (856) 751-2140. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact the Compliance Officer at (856) 751-2140. All complaints must be submitted to the Practice in writing at 16 Rockhill Road, Suite A, Cherry Hill, NJ 08003. There will be no retaliation for filing a complaint.

EffectiveDate:
The effective date of this Notice is 4/14/03.

APPLE PHYSICAL THERAPY, LLC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personality identifiable health information for treatment, payment or health care operations, is made pursuant to the requirements of 45 CFR§164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personality identifiable health information about me by Apple Physical Therapy (the "Practice") for the purpose of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any health care operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: Apple Physical Therapy, Attn: Practice Compliance Director 16 Rockhill Road, Suite A, Cherry Hill, NJ 08003
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/for disclosure of my health information (leave blank if no restrictions:_____
_____.

I understand the foregoing provisions, and I wish to sign this acknowledgement authorizing the use of my personally identifiable health information for the purpose of treatment and health care operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Signature of patient or Representative _____ Date _____

Patient's Name_____

Date of Birth_____
Social Security Number_____

Name of Personal Representative (If Applicable) _____ Relationship to Patient_____

To be Completed by the Practice
The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:
_____ Accepted _____Denied _____Not Applicable

_____ Other (explain) _____

Signature of Authorized Practice Representative _____ Date_____