302 W. Main St, Avon, CT 06001 860-679-0430

EXERCISE CONSENT FORM

I wish to join/be treated by Magna Physical Therapy & Sports Medicine Center, LLC to improve my fitness level/receive physical therapy. Before entering the program I understand that I will need to complete a medical history form for the purpose of detecting any condition, which may indicate that I should not participate in a fitness program or that my program may need to be altered. I understand that withholding information about my health may result in an incorrect exercise prescription, which may cause harm to me. I understand that if I have certain pre-existing medical problems, or if concerns develop during the course of my health history, the staff will request information from my physician, and will request his/her consent for my participation. I understand the staff will review all data submitted and develop a safe and effective exercise program for me. All information received or generated about me is strictly confidential.

I understand that no assurance can be given to me that participation in a fitness program will increase my functional/athletic capacity, improve my blood sugar and blood pressure, assist in weight loss and tone my muscles; however current research indicates that improvement in these areas can be achieved with active participation in an exercise program. In addition, feelings of increased confidence and a sense of well being usually occur.

The exercises are designed to place a gradually increasing workload as tolerated on my cardiovascular and musculoskeletal system and thereby improve its functioning. The reaction of my body cannot be accurately predicted. I understand the risks associated with exercise include blood pressure abnormalities, lung congestion, irregular heartbeats, muscle pain and soreness, and in very rare instances a "heart attack", "stroke" or "cardiac arrest." I understand that the Magna Physical Therapy & Sports Medicine Center staff will take all measures to avoid such happenings. I understand that providing the staff with current information about changes in my health, which includes any illness or symptoms I experience in the performance center or at home, is essential for the Magna Physical Therapy & Sports Medicine Center staff to determine if any modifications need to be made in my exercise program. I understand that if I do not inform the Magna Physical Therapy & Sports Medicine Center staff that I may be putting myself at risk for injury or serious medical problems.

I understand that I am required to respect the rights of all participants and staff members involved with the Magna Physical Therapy & Sports Medicine Center. I understand that the staff has the right to address concerns about my health with my physician and may ask to temporarily discontinue my exercise program until my physician evaluates my condition and advises me on my return.

I acknowledge that no guarantees can be made to me as a result of my participation in the program. I hereby release Magna Physical Therapy & Sports Medicine Center, LLC, its affiliated entities, employees, trustees and their respective representatives and agents from all claims, liabilities, and causes of action arising or associated with my participation in this program. I have read the foregoing or it has been read to me, and I understand its contents and significance.

Client/Participant/Guardian **Signature**:____________________________**Date**:_______________

MPT&SMC Witness **Signature**:_________________________________**Date**_______________

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INFORMATION / CONSENT FOR CARE & TREATMENT

Name: ____ Date of Birth: _____________________

Address: ____City:__________________Zip:____________

Home Phone: ___________________ Business: ________________ Cell Phone: __________________

E-Mail Address: ____ Marital Status: M S

Occupation: ______________________________ Primary Insurance: __________________________

Emergency Contact: ____Phone:_____________________

Primary Care MD: ____Phone:_____________________

Specialist MD: ____Phone:_____________________

How did you hear about Magna Physical Therapy & Sports Medicine Center? ____________________

Would you like information about our Personal Training programs or Pilates Classes? Yes No

Are you interested in Nutritional Counseling? Yes No

Do you wish to speak to a social worker at this time? Yes No

- It is our policy that office visits be paid for at the time services are rendered, this includes co-payments and deductibles. Once your insurance carrier processes your claim we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ***Magna Physical Therapy.***

- The above may not apply for those patients that are considered Worker's Compensation, Medicare Primary or who have benefits with a balance billing contact, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

- ***Magna Physical Therapy*** will accept the following forms of payment for services provided: cash, personal check or credit card (Visa, MasterCard and Discover).

- We verify your insurance benefits as a courtesy to you. However, ***Magna Physical Therapy*** does not accept responsibility for any incorrect information given by your insurance carrier regarding your insurance benefits or benefit plans.

- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

- I, the undersigned, do hereby agree and give my consent for ***Magna Physical Therapy*** to furnish medical care and treatment to be considered necessary and proper in diagnosing or treating his/her physical and mental condition.

- I hereby authorize ***Magna Physical Therapy*** to release all information necessary, including medical records to secure payment.

- *I understand I will be charged a $25 No-Show fee if I fail to keep an appointment without at least twenty-four hour notification.*

All of the above information is correct to the best of my knowledge:

Patient/Client/Guardian/SIGNATURE: ___________________________ **Date**:________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on September 01, 2006, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. We will attempt to disclose only information that is pertinent to your care.

Treatment: We may use or disclose your medical health information to a physician or other healthcare provider providing treatment to you as is necessary to benefit your health.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This information will be limited to your medical information, unless specifically requested by medical insurance and we obtain your release.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters) that disclose medical information and appointment times.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your healthcare information. You must allow at least 48 hours for our staff to accommodate these requests. If you prefer, we will prepare a summary or an explanation of your health information for a nominal fee. Contact us using the information listed at the end of this Notice.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you have questions or concerns about our privacy practices please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Brian A. Magna

Telephone: 860-679-0430 Fax: 860-679-0431

302 W. Main Street, Suite 204 Avon, CT 06001

Name :____________________________ Signature : ______________________

Date :____________

Magna Physical Therapy & Sports Medicine Center LLC

Medical History

Name: ____________________________ Date of Birth: _____________

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

☐ headaches ☐ numbness/tingling ☐ constipation
☐ fever/chills/sweats ☐ muscle weakness ☐ diarrhea
☐ nausea/vomiting ☐ dizziness/lightheaded ☐ falls
☐ weight loss/gain ☐ heartburn/indigestion ☐ fainting
☐ difficulty maintaining balance ☐ difficulty swallowing ☐ cough
☐ shortness of breath ☐ changes in bowel/bladder ☐ fatigue

Have you EVER been diagnosed with any of the following conditions?

☐ osteoporosis ☐ depression ☐ pneumonia
☐ heart problems ☐ lung problems ☐ diabetes
☐ chest pain/angina ☐ tuberculosis ☐ cancer
☐ high blood pressure ☐ multiple sclerosis ☐ asthma
☐ circulation problems ☐ rheumatoid arthritis ☐ epilepsy
☐ blood clots ☐ other arthritic condition ☐ ulcers
☐ eye problem/infection ☐ liver problems ☐ stroke
☐ urinary tract/bladder infection ☐ anemia ☐ hepatitis
☐ kidney problem/infection ☐bone/joint infection
☐ sexually transmitted disease ☐pelvic inflammatory disease
☐ chemical dependency ☐ thyroid problems

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions ? (check all that apply)

☐ tuberculosis ☐ diabetes ☐ cancer
☐ heart problems ☐ thyroid problems ☐ stroke
☐ high blood pressure ☐ depression ☐ blood clots

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**

Is this something with which you would like help? **Yes No**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **Yes No**

Have you received any of the following treatments in the past year:

Chiropractic	**Yes No**	Speech Therapy	**Yes No**
Home Care Physical Therapy	**Yes No**	Occupational Therapy	**Yes No**

Please list any surgeries you have had:

________________________________ Date: _______________
________________________________ Date: _______________
________________________________ Date: _______________

Please list any medications you are currently taking or attach a medication list:

Drug	Dose	Reason

Have you ever taken steroid medication for any medical conditions? **Yes No**
Have you ever taken blood thinning or anticoagulant medications for any medical condition? **Yes No**

What date did your current symptoms start?______________________________

What do you think caused your symptoms?______________________________

My symptoms are currently: **Getting Better Getting Worse Staying the Same**

I should not do physical activities that might make my pain worse:
Disagree Agree Unsure

Treatment received so far for this problem (chiropractic, injections, etc.)
____

Please list any tests performed for this problem (X-ray, MRI, labs, etc.)
____

Have you ever had this problem before? **Yes No** Did you have treatment? **Yes No**

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

Are you currently able to sleep at night due to your symptoms?

No problem sleeping **Difficulty falling asleep**

Awakened by pain **Sleep with medication**

When your symptoms worse?

Morning **Afternoon** **Evening** **Night** **After exercise**

When are 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: ______/10

The best your pain has been during the last 24 hours: ______/10

The worst your pain has been during the past 24 hours: ______/10

Client/Patient/Guardian Signature:

____ Date: ______________