JUST BE FIT, INC.
PHYSICAL THERAPY
EXERCISE BASED REHABILITATION

1. Patient Information:

Date:_____

Last Name: _____ First Name:_____ M.I_____

Home Address:_____

City: _____ State:_____ Zip:_____

DOB:_____/_____/_____ Gender: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ D

Cell phone :_____ Home phone:_____ Work phone:_____

E-mail Address:_____ Emergency Contact and phone #:_____

How would you like to be contacted: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Mail

Referring Physician:_____ Secondary Physician:_____

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2. Primary Insurance Information:

Self Pay - YES ☐ NO ☐

Primary Insurance Company Name:_____ Phone:_____ Policy

Holders Name:_____Birthdate:_____

Relationship To Patient:_____

Secondary Insurance Company Name:_____Phone:_____

Policy Holders Name:_____Birthdate:_____

Relationship To Patient:_____

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3. Responsible Party/ If patient is a Minor:

Last Name:_____First Name:_____

☐ Responsible for Payment If yes please provide Social Security number:_____ DOB:_____

Relationship To Patient:_____

Home Phone:_____ Cell:_____ E-mail address:_____

Authorization and Assignment

I hereby authorize my insurance carrier to make benefit payments directly to Just Be Fit, Inc/M.L. Billing Co., on my behalf. I hereby acknowledge my financial responsibility for fees not paid by this assignment and agree to pay for any collection and/or legal fees incurred if my account becomes delinquent.

Signature:_____Date:_____

4. Informed Consent to Evaluate / Treat:

By my signature, which appears below, I hereby grant my permission for and request that I be evaluated, and treated by the physical therapist and/or kinesiotherapist, according to the plan of care developed by the physical therapist and/or kinesiotherapist and prescribed by my physician in consultation with the therapist(s).

I understand that the purpose of this program is to enhance my recovery from an illness, injury or surgery. It has been explained to me that there exists the likelihood of changes in the treatment program as my condition changes and I hereby grant my permission for all modifications and changes to the treatment program deemed necessary by the therapist(s).

The procedures and or modalities to be used have been explained to me and I have had the opportunity to ask any questions I had, and acknowledge that I have received answers that are satisfactory to me. I understand that the success of this, or any other medical treatment program depends on my involvement and cooperation with the program including regular attendance at all treatment sessions and conscientious follow through with any home exercises or procedures which may be prescribed by the therapist(s). I understand what is expected of me as a patient and agree to cooperate to the best of my ability.

I hereby attest that I have read and agreed to all statements made above and that my participation in this physical and or/ occupational therapy treatment program is fully voluntary.

_____ _____/_____/_____

Signature of Patient Date

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5. Authorization to Disclose Health Information

Patient Name_____ Health Record Number_____

Date of Birth_____

1. I authorize the use or disclosure of the above named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

2. The type and amount of information to be used or disclosed is as follows : (include dates where appropriate)
   - ☐ Evaluation(s)
   - ☐ Progress Notes
   - ☐ Most recent history and physical
   - ☐ Most recent discharge summary
   - ☐ Entire Record

   Other_____
   _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I t may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization:_____
   _____

   Address_____
   _____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Healthcare Management office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 12 months.

6. I understand that authorizing this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules

_____ _____

Signature of Patient or Legal Representative Date

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6. CANCELLATION/ MISSED APPOINTMENT POLICY

Please be aware that if you need to cancel your therapy appointment we would appreciate as much advance notice as possible; therefore call no later than 24 HOURS prior to your scheduled appointment date and time. Just Be Fit, inc has the right to bill you personally, the cost of a missed appointment ($95.00) , if you do not provide at least **24-hours notice of a cancellation.** Also, if you miss **THREE** consecutive scheduled therapy appointments without calling to cancel or reschedule your appointment you will be discharged immediately from physical therapy. This policy will be enforced after your initial therapy appointment.

Insurance Benefits:
All patients are required to know their Physical Therapy benefits. As a courtesy Just Be Fit, Inc, will call to verify, however, this is not a guarantee of benefits or payment. What the company tells us can be denied or changed during and after the payment cycle. You are responsible for all denied claims. I understand that I am responsible to giving Just Be Fit, Inc any change of information with my insurance coverage. I authorize my insurer to pay any benefits for services rendered directly to Just Be Fit, Inc. I understand that anything not covered by insurance is my full responsibility.

I agree to pay the fees outlined in this policy.

Initial _____

7. Acknowledgement of Receipt of Just Be Fit, Inc & Just Be Fit, Inc's Financial Policies

Thank you for choosing Just Be Fit, Inc for your healthcare and physical therapy needs. Please read the following policies and complete the sections below.

NOTICE OF PRIVACY PRACTICES: We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our client services staff to acknowledge that you have been provided a copy of our notice.

FINANCIAL POLICY: Just Be Fit, Inc has contracts with many insurance plans. **Due to the numerous healthcare plans available, it is the patient's responsibility to verify that we are in network with your specific insurance plan.**

If we contract with your plan, we will file a claim (for physical therapy services) to your insurance company. You will be responsible for any co-pays, deductibles, purchased products, and/or non-covered service. If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of your service.

* It is your responsibility to provide Just Be Fit, Inc with your current insurance information. Failure to do so may result in charges being billed directly to you.

* Any service that is not covered by your insurance company, for whatever reasons, is your financial responsibility. **Any outstanding balances over 90 days will be charged to your credit card. If applicable a 3% late fee will be accessed to balances over 90 days and/or patient will be sent to our collection agency.**

Please provide your credit card number in the line below:

_____ _____ _____

Credit Card Number Exp Date 3/4 Digit Code

I certify that I have been provided with the *Notice of Privacy Practices* and the Patient Financial Policies.
I have read and accept the policies of Just Be Fit, Inc.
I authorize Just Be Fit, Inc to charge my credit card any outstanding balances over 90 days as well as the appropriate cancelation fee if needed.
I authorize payment of medical benefits to the named provider for professional services rendered.
I authorize the release of any medical information necessary to process any claims filed.

_____ _____/_____/_____

Signature of Patient or Legal Representative Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgment,* but was unable to do so as documented below:

Date:	Initials:	Reason:

7. MEDICAL HISTORY:

Have you ever had, or do you currently have, any of the following:

( ) Alcohol Abuse Problems
( ) Anemia
( ) Aneurism
( ) Asthma
( ) Bronchitis
( ) Chronic Obstructive Pulmonary Disease
( ) Cerebral Palsy
( ) Coronary Artery Disease/Heart Disease
( ) Diabetes Type I, Type II
( ) Emphysema
( ) Fibromyalgia
( ) Gout
( ) Hearing Loss
( ) Hemorrhoids
( ) High Blood Pressure / Hypertension
( ) High Triglycerides
( ) Hypoglycemia
( ) Kidney Disease
( ) Lung Disease
( ) Muscular Dystrophy
( ) Osteoporosis
( ) Paralysis
( ) Spina Bifida
( ) TMJ
( ) Tumors
( ) Varicose Veins
( ) Allergies
( ) Arthritis (Osteo/Rheumatoid/AS)
( ) Angina
( ) Back/Spinal Injury
( ) Cancer
( ) Cerebral Vascular Accident/Stroke
( ) Coronary Vascular Disease
( ) Circulatory Problems
( ) Embolism
( ) Epilepsy
( ) Gastrointestinal/Stomach Problems
( ) Head Injury
( ) Heart Attack
( ) Hernia
( ) High Cholesterol
( ) Hyperglycemia
( ) Crohn's Disease
( ) Joint Problems (Knee/Shoulder/Hip/Back)
( ) Low Blood Pressure
( ) Multiple Sclerosis
( ) Nervous/Emotional Tension
( ) Parkinson's Disease
( ) Poliomyelitis
( ) Spinal Cord Injury
( ) Thyroid Problems
( ) TBI

Please comment here on any marked answers from above:

_____

_____

Have you recently experienced:

( ) Back/leg Pain_____
( ) Blurred or double vision _____
( ) Bowel/Bladder changes _____
( ) Brain Fog_____
( ) Calf pain with exercise_____
( ) Change in speech pattern_____
( ) Chest pain or pressure_____
( ) Constant pain unrelieved by rest or movement_____
( ) Difficulty keeping balance_____
( ) Difficulty sleeping_____
( ) Difficulty swallowing_____
( ) Dizziness, fainting, or blackouts_____
( ) Falls_____
( ) Fatigue_____
( ) Irregular heart beat_____
( ) Headaches/migraines_____
( ) Muscular pain at rest_____
( ) Muscular pain with exertion_____
( ) Numbness or tingling in arms, hands or legs_____
( ) Ringing in ears_____

( ) Shortness of breath_____
( ) Stroke
( ) Swollen, stiff, or painful joints_____
( ) Tremors_____
( ) Unexplained weight gain_____
( ) Unexplained weight loss_____
( ) Unusual skin coloration_____
( ) Unusual weakness or fatigue_____
( ) A wound that does not heal_____
( ) Other_____

Current Height:_____ Current Weight:_____

Have you undergone a complete medical exam within the last year? ( )YES ( ) NO

Please list all medications you are taking: ☐ check box if list provided

Name Reason Amount Frequency Side Effects

_____
_____
_____

Please list any homeopathic, herbal, vitamin, and/or mineral products including THC or CBD products that you are currently taking for the treatment of any condition or deficiency:

Name Reason Amount Frequency Side Effects

_____
_____
_____

Please describe any surgery and/or hospitalizations:

Procedure Reasons Date

_____
_____

Identify any assistive devices you are currently using (cane, brace, etc.), whether the device was prescribed by a physician, and the reason for the device:

_____
_____

Please identify any past or ongoing treatments by a physician, physical therapist, chiropractor, massage therapist, acupuncturist, etc:

_____
_____

Has your physician ever advised you against exercise? ( ) YES ( ) NO
If YES, why?_____

WOMEN'S HEALTH:

1. Are you pregnant? ( ) YES ( ) NO
2. When was your last menstrual cycle? _____
3. Are you currently ( ) premenopausal ( ) postmenopausal ( ) menopausal
4. List any symptoms that accompany your menstrual cycle:_____

_____
_____

JUST BE FIT, INC.
PHYSICAL THERAPY
EXERCISE BASED REHABILITATION

8. INTERVIEW:

Reason for today's visit:_____
_____
_____
_____

*If your visit is related to an injury, check the appropriate response in the box below. If it is not related to an injury, skip this section.

The injury is due to: car accident ☐ work injury ☐ sports injury ☐ fall ☐ other_____

The injury occurred at: home ☐ work ☐ school ☐ other_____

Is legal action / litigation pending due to this injury? yes ☐ no ☐

Date of onset / injury _____/_____/_____ Symptoms_____

Location of Symptoms:_____ ☐ right ☐ left ☐ both ☐ NA

Check each characteristic that best describes your problem:

QUALITY:	DURATION:		CONTEXT:	SYMPTOM AGGRAVATION:
Sharp ..... ☐	Infrequent....☐	Daily.....☐	Worsening..... ☐	Activity.....☐
Throbbing..... ☐	Constant .....☐	Weekly... ☐	Reccurent..... ☐	Position Change... ..☐
Aching..... ☐	Hourly..... ☐		More Frequent. ☐	Repetitive Motion.. ☐
Burning..... ☐				Fatigue..... ☐
Cramping..... ☐				Other..... ☐

SEVERITY:	TIMING:		SYMPTOM RELIEF:	
Mild..... ☐	After Activity..☐	Pivoting.....☐	Rest.....☐	Brace.....☐
Moderate.....☐	Walking.....☐	Overhead use..☐	Heat.....☐	Injection.....☐
Severe.....☐	Running.....☐	Throw.....☐	Cold.....☐	Medication.....☐
	Stairs.....☐	Lift.....☐	Elevation...☐	Other:.....☐
	Squatting.....☐	Other.....☐	Physical therapy..... ☐	

Treatment: Describe treatment and response for current problem: _____
_____
_____
_____

Have you had a problem with this area before? yes ☐ no ☐ If yes, describe problem and prior treatment:
_____
_____
_____

Have you had any diagnostic tests for this problem? yes ☐ no ☐ If yes, what and where? _____
_____
_____

Do you have a copy of the test results? yes ☐ no ☐ Did you bring them with you? yes ☐ no ☐

Has a physician recommended surgery? yes ☐ no ☐ Name of previous treating physician (s), if any:___
_____
_____

What is the level of your pain on a scale of 0-10? _____

What are your limitations?_____
_____
_____

In what activities is the pain (or other disability) manifested?_____
_____
_____
_____

What was your activity level before the injury? Describe:_____
_____
_____

What are your goals from physical therapy?_____
_____
_____

Signature:_____Date:_____

We appreciate your courtesy and thank you for your cooperation. Just Be Fit, Inc looks forward to providing our Physical Therapy services to you.

Should you have any questions concerning our professional services or office procedures, please ask.

Sincerely,

Just Be Fit, Inc Management

Notice of Health Information Practices
This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information
Each time you visit a hospital, physician or other healthcare provider a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information often referred to as your health medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among may health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures or your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided for in CFR 164.525
- Amend your health record as provided in 45 CFR 164.528
- Obtain as accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communication of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities
This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not disclose your health information without your authorization, except as described in this notice.

For more information or to Report a Problem
If you have questions and would like additional information, you may contact Just Be Fit, Inc. at (847) 444-1348.

If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
For example: Information obtained by your physical therapist will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of your physical therapist. Your therapist will then record the actions he/she took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from therapy.

We will use your health information for payment
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the corporate compliance officer, or other members of our physical therapy staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates:
There are some services provided in our organization through contacts with business associates. Examples include our billing service. When these services are contracted, we may disclose your health information to our business associate so that the can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with family:
Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment relates to your care.

Research:
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing:
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers Compensation:
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Effective Date: 3-20-13