Dear Patient,

We are pleased that you have chosen Aspire Health & Wellness for your physical therapy and health and wellness needs.

For your convenience, we have provided our patients forms on our website. Please take the time to fill these forms out completely prior to your scheduled appointment. On your first visit, please bring the following:

- For patients on a “cash pay” basis, please bring your completed patient forms and a photo I.D.
- If you would like us to provide you with a super bill to submit to your insurance company for reimbursement, we require a prescription/diagnosis from your doctor, completed patient forms and a photo I.D.

To download and print the forms, you will need the free Adobe Acrobat Reader program.

Sincerely,
Aspire Health & Wellness

Patient Information Form

Patient Name (Last, First, Middle):	Date of Birth: Age: Sex: M F
Home Address: City: State: Zip:	
Home Phone: Cell Phone: Work Phone, Ext: Email Address:	
Driver's License Number: SSN:	Primary Care MD:
Marital Status: Single Married Other	Employment Status: Emp Unem Retired Student
Emergency Contact Name (Last, First, Middle): Relationship:	
Emergency Contact Home Address: City: State: Zip:	
Emergency Contact Home Phone: Cell Phone: Work Phone: Email Address:	
Financially Responsible Party (if other than patient): Relationship:	
Financially Responsible Party's Home Address: City: State: Zip:	
Financially Responsible Party's Home Phone: Cell Phone: Work Phone:	
Financially Responsible Party's SSN: Date of Birth: Email Address:	

I grant permission to Aspire Health & Wellness to perform physical therapy services. During my initial evaluation, the nature of the services that will be performed as well as the potential risks of care will be explained to me. If I become ill while undergoing treatment, I give permission to Aspire Health & Wellness to administer treatments which they consider necessary to my well-being. Further, I understand that I am financially responsible for all payments to Aspire Health & Wellness. My signature below indicates that I understand and give consent to be treated as explained above.

Patient Signature (Guardian if patient is a minor): _______________________ Date: _________________________

Cancellation Policy

At Aspire Health & Wellness, we strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals, you must do your part, and your most important part is to make each and every appointment.

We expect you to keep all your appointments; however should you need to cancel, please note that we require a **24-hour notice**. If you need to cancel, please call and reschedule. If you do not cancel with a **24-hour notice** or if you do not show for an appointment, **you will be charged $45** for the missed appointment.

Thank you for choosing Aspire Health & Wellness and we are looking forward to working with you and helping you reach your goals.

By signing below, I acknowledge and agree that I have personally reviewed the information on this sheet and agree to the terms hereof.

Patient Signature (Guardian if patient is a minor): ___________________ Date: _______________

Physical Therapy Medical History Intake Questionnaire

Name: ____ Date: __________
Age: __________________ DOB: ___________________ Sex: ___________________
Referring Doctor: ______________________ Family Doctor: _____________________

Mechanism of Injury:

• What is the complaint that brought you here? ____

• When did this complaint begin, or recently become worse? Approximate Date: ____________________

• What caused this complaint? ____

• Have you had surgery associated with this complaint? □ Yes □ No
  If yes, what? ________________________________ Date: ______________________________

• Was there a specific injury? □ Yes □ No If yes, what happened? ________________________________

• Is this complaint auto related? □ Yes □ No

• Does this complaint affect your activity choice, tolerance, efficiency or effectiveness? □ Yes □ No
  If yes, what activities? ____

• What makes this complaint better? ____
  Worse? ____

• Does this complaint affect your comfort, mood or ability to sleep? □ Yes □ No

Pain Scale:

Please circle the **lowest and highest** your pain has been in the last 2 weeks. Also put an X for your **current** level of pain.

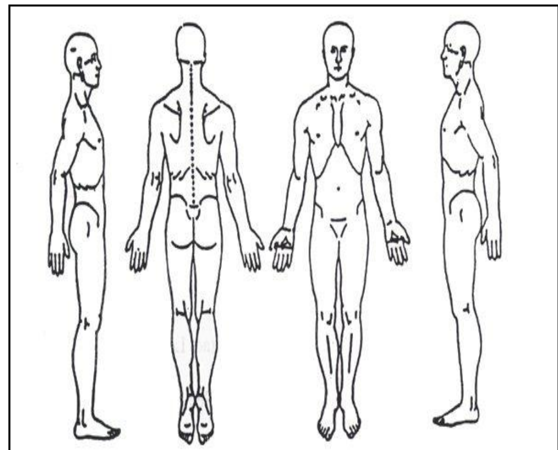
0 None	1 Just noticeable	2	3 Mild, in background	4	5 Moderate, bothersome	6	7 Severe, can't function	8	9	10 Excruciating ER time

• What symptoms are you experiencing with this complaint?
□ Swelling □ Loss of balance or coordination
□ Loss of motion □ Numbness □ Pain
□ Weakness □ Tingling
□ Other (Specify) ____________________________

• How frequent are the symptoms experienced?
□ Constant □ Intermittent

• What tests have you had for this complaint?
□ X-ray □ CT Scan □ MRI □ Bone Scan
□ EMG/NCV (Nerve Test) □ Lab/Blood Test

Draw pain areas on body diagrams:



• What treatment have you had for this complaint? □ Physical Therapy □ Occupational Therapy
□ Chiropractic □Massage □ Athletic Training □ Alternative Medicine (specify):__________________

• Is this complaint work related? □ Yes □ No
If yes, your employer's name: ____
Your Occupation: _________________________________ Last Date Worked: ______________

About your General Health:
• Please check all medical conditions that you have, or have had.

□ Arthritis	□ Heart Disease	□ Seizures	□ Thyroid Problems	□ Panic Attack
□ Cancer	□ High Blood Pressure	□ Pace Maker	□ Dizziness/Falls	□ Diabetes
□ Lung Disease	□ Stroke	□ Depression	□ Headaches	□ Anxiety
□ Heart Attack	□ Metal Implants	□ Morning Stiffness	□ Hepatitis	□ Shingles
□ Asthma	□ Stomach Disorder	□ Gout	□ Multiple Sclerosis (MS)	
□ Deep Venous Thrombosis (DVT)		□ Other: _________________________________		

• Please check all of the following items that currently apply to you.

□ Hearing Problems	□ Learning problems	□ Bowel or Bladder Control	
□ Visual Problems	□ Pregnant	□ Smoke	□ Chemical Dependency

Please list history of surgeries: ____
____

Medication: Include prescription, over-the-counter medications and supplements. If you have a list, we can copy it. ____
____

Allergies: ____

Patient Goals:
What is/are your main goal(s) for physical therapy? ____
____

Functional Limitation:
• What activities are you currently unable to do? ____

• What activities are very difficult to do? ____

• What activities are moderately difficult to do? ____

• What activities are slightly difficult to do? ____

Any other concerns you may have that we should be aware of? _______________________________
____

By signing below, I attest that I have personally reviewed the information on this sheet.

Patient signature: ____ Date: ______________________

Therapist signature: ____ Date: ______________________

Notice of Patient Information Practices

Your Health Information

THIS NOTICE DESCRIBES HOW YOUR PERSONAL MEDICAL INFORMATION MAY BE USED AND/ORDISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEWCAREFULLY.

Legal Duty of Aspire Health & Wellness

Aspire Health & Wellness is required by law to protect the privacy of your personal health information, provide this notice about its information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Your protected health information may be used and disclosed by those involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice and any other use required by law. The following describes various ways that Aspire Health & Wellness may use and disclose medical information about you.

- **For Treatment.** Aspire Health & Wellness may use and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers, and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.
- **For Payment.** California state law requires a physician's referral in order for you to use your insurance company for physical therapy services. At Aspire Health & Wellness, we treat patients on a "cash pay" basis without a physician's referral. As such, Aspire Health & Wellness is not contracted with any insurance plans, which enables us to provide a full range of services. If necessary, however, we can provide you with a super bill to submit to your insurance company for reimbursement. As such, we may use and disclose information about you. Your protected health information will be used, as needed, to obtain payment for treatments and health care services received at Aspire Health & Wellness.
- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Related Products and Services.** We may use and disclose medical information to tell you about related products or services that may be of interest to you.
- **Healthcare Operations.** We may use and disclose medical information about you for our own operations. For example, we may use information about you to review the quality of care and services you receive; to provide you medical file management or coordination of medical services such as between treating therapists or between doctor and therapist.
- **As Permitted or Required by Law.** Information provided by you may be used or disclosed when required to do so by Federal, state, or local law.
- **Authorization.** Other use and disclosures of protected health information will be made only with your written authorization, unless otherwise permitted or required by law. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization at any time to stop future disclosures.

- **To Avoid Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Patient's Individual Rights

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect, review and obtain a copy of your medical information at any time.
- **Right to Amend.** You have the right to request that we correct any inaccurate or incomplete information we have about you in our records. You have the right to request, in writing, an amendment for as long as the information is kept by or for Aspire Health & Wellness.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your medical information, where we have disclosed your medical information for reasons other than treatment, payment and other related administrative purposes.
- **Right to Request Restrictions.** You may also request in writing that we are not to use or disclose your medical information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. However, we are not are not legally required to agree to these requests.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at anytime.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

Concerns and Complaints

If you are concerned that your privacy rights have been violated, you have the right to file a complaint with us, or you may also send a written complaint to the Secretary of the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Declaration of Privacy of Health Information

All medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the US Department of Health and Human Services (HHS), and are covered by HIPAA (Health Insurance Portability and Accountability Act of 1996).

Consent Form

I have read and fully understand Aspire Health & Wellness' "Notice of Patient Information Practices." I understand that Aspire Health & Wellness may use or disclose my personal health information 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 personal health information is used and disclosed for treatment, payment and administrative operations if I notify Aspire Health & Wellness.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Aspire Health & Wellness' "Notice of Patient Information Practices." I understand that I retain the right to revoke this consent by notifying Aspire Health & Wellness in writing at any time.

____

Patient Name

____

Patient Signature (Guardian if patient is a minor)

____

Date

WAIVER OF LIABILITY, ASSUMPTION OF RISK & INDEMNITY AGREEMENT

I, _____________________________ ("Participant"), acknowledge and agree that I have voluntarily applied to participate in the personal training/exercise activities (hereinafter referred to collectively as "Activities") of Aspire Health & Wellness.

It is the purpose of this Waiver of Liability, Assumption of Risk and Indemnity Agreement (hereinafter referred to as the "Agreement") to exempt, waive and relieve Aspire Health & Wellness and its respective officers, employees, volunteers, agents, contractors, representatives and its and their successor and assigns (collectively "Releasees"), from any and all claims (including third party claims), expenses, liabilities, losses and damages of any kind whatsoever, including personal injury, property damage, and wrongful death, which are asserted against Aspire Health & Wellness and its Releasees, resulting from participation in the Activities, except as a direct result of the gross negligence or willful misconduct of Aspire Health & Wellness and its Releasees.

Waiver of Liability. For and in consideration of Participant's registration for the Activities by Aspire Health & Wellness and the use of the premises and facilities, I, Participant, forever waive, release, and relinquish Aspire Health & Wellness and its Releasees from any and all claims for liability and cause(s) of action, including for personal injury, property damage, or wrongful death occurring to Participant arising out of participation in the Activities or any activity incidental thereto, whenever or however they occur, except as a direct result of the gross negligence or willful misconduct of Aspire Health & Wellness and its Releasees . I also acknowledge and agree that my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives will not make a claim against, sue, or attach the property of Aspire Health & Wellness or any of its Releasees for any claim they now have or may have in the future for injury, death, or property damage related to (i) Participant's participation in the Activities, (ii) the negligence or other acts, whether directly or indirectly connected to the Activities or not, and however caused, by Aspire Health & Wellness or any of its Releasees, or (iii) the condition of the premises and facilities where the Activities occur, whether or not I am then participating in the Activities.

Assumption of Risk. I, Participant, understand and assume all risks relating the Activities and understand that the Activities involve risks to Participant's person including bodily injury, partial or total disability, paralysis and death, and damages which may arise therefrom and that I have full knowledge of said risks. I further acknowledge that there may be risks and dangers not known or not reasonably foreseeable at this time. I acknowledge, understand and agree that all of the risks and dangers described throughout this Agreement, including those caused by negligence of Participant and/or others, are included within the waiver, release and relinquishment described in the preceding paragraph.

I acknowledge, understand and assume the risks, if any, arising from the conditions of and use of the premises and facilities and acknowledge and understand that included within the scope of this Agreement is any cause of action (including any cause of action based on negligence) arising from the performance, or failure to perform, maintenance, inspection, supervision or control of the premises and for the failure to warn of dangerous conditions existing at premises, or negligent supervision or instruction by Aspire Health & Wellness or any of its Releasees.

Indemnification. I, Participant, agree if any claim for Participant's personal injury or wrongful death is commenced against Aspire Health & Wellness or any of its Releasees, I shall defend, indemnify, and hold harmless Aspire Health & Wellness and its Releasees from any and all claims, actions, suits, causes of action, liabilities and costs, including attorney's fees, by whomever or wherever made or presented for Participant's personal injuries, property damage or wrongful death.

Severability. I understand that this Agreement is written to be as broad and inclusive as legally permitted by the State of California. I agree that if any portion this Agreement is held invalid or unenforceable, I will continue to be

bound by the remaining terms. If any part of this Agreement is rendered unenforceable, the remainder of this Agreement shall remain enforceable to the full extent, if any, allowed by controlling law. This Agreement affects Participant's legal rights, and as such, Participant may wish to consult an attorney concerning this Agreement.

Construction. This Agreement or any uncertainty or ambiguity that may be found herein shall not be construed against any one Party, but shall be construed as if all Parties to this Agreement jointly prepared this Agreement.

Acknowledgment of Understanding. I AM AWARE THAT THE ACTIVITIES ARE HAZARDOUS ACTIVITIES AND THAT I COULD BE SERIOUSLY INJURED OR EVEN KILLED. I AM VOLUNTARILY PARTICIPATING IN THESE ACTIVITIES WITH KNOWLEDGE OF THE DANGER INVOLVED, AND AGREE TO ASSUME ANY AND ALL RISKS OF BODILY INJURY, DEATH OR PROPERTY DAMAGE, WHETHER THOSE RISKS ARE KNOWN OR UNKNOWN.

I have read this Agreement and fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing this Agreement freely and voluntarily, that I knowingly assume all such risks, and I have not relied upon any representation of Aspire Health & Wellness or any of its Releasees. I intend by my signature to be a complete and unconditional release of all liability, to the greatest extent permitted by law. I also agree to indicate in the space provided below any health problems or physical impairments that would affect my ability to participate in the Activities.

I am the parent or legal guardian of the Participant. I understand the legal consequences of signing this document, including (i) releasing the Aspire Health & Wellness and its Releasees from all liability on my and the Participant's behalf, (ii) promising not to sue Aspire Health & Wellness and its Releasees on my and the Participant's behalf, (iii) and assuming all risks of the Participant's participation in the Activities. I agree to indicate in the space provided below any health problems or physical impairments that would affect Participant's ability to participate in the Activities. I allow Participant to participate in the Activities. I understand that I am responsible for the obligations and acts of Participant. I agree to be bound by the terms of this Agreement.

____
Signature of Participant

____
Print Name of Participant

____
Date

____
Age (if Minor)

If Signed by Parent or Guardian: I verify that the dangers of the Activities and the significance of this Agreement were explained to the Participant and that the Participant understood them.

____
Signature of Parent/Guardian of Participant if Minor

____
Print Name of Parent/Guardian of Participant if Minor

____
Date

Does Participant have any health problems and/or physical impairments that could affect participation in the Activities?

______Yes ______No

If yes, please explain:____