Elite Physical Therapy and Performance, PLLC
Address: 33487 Harper Ave. Clinton Township, MI 48035
Phone #: 586-388-0016
Email: info.elitephysicaltherapy@gmail.com

Patient Name: _____ Date: _____

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Elite Physical Therapy and Performance, PLLC, through its appropriate personnel (Owners and Employees), to perform the evaluation and treatment procedures that are deemed necessary by the physician in the treatment of my condition. Elite Physical Therapy and Performance, PLLC provides many therapy programs that could potentially increase levels of pain and discomfort temporarily, cause soreness, bruising, or other injury, during or after participation in the exercise/therapy programs.

By signing this form, I hereby release Elite Physical Therapy and Performance, PLLC (Owners and employees) from any liability, claims, demands, and causes of action, now or in the future, resulting from treatment.

I further authorize Elite Physical Therapy and Performance, PLLC to equip the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment. I am assigning my therapy benefits to Elite Physical Therapy and Performance, PLLC for the services in which I receive and authorize my insurance carrier to make payment to Elite Physical Therapy and Performance, PLLC on my behalf. Elite Physical Therapy and Performance, PLLC reserves the right to seek reimbursement from any and all insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. Elite Physical Therapy and Performance, PLLC is HIPAA compliant with regard to information sharing policies.

_____ (initials)

NOTICE OF PRIVACY PRACTICES:

By signing this form, you acknowledge that you received or have been provided an opportunity to review the Notice of Privacy Practices of Elite Physical Therapy and Performance, PLLC. This Notice of Privacy Practices is in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) and provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practice is subject to change.

_____ (initials)

PATIENT FINANCIAL OBLIGATION

Elite Physical Therapy and Performance, PLLC is a health care provider who is authorized and credentialed to bill your medical insurance company to receive treatment. As a healthcare provider authorized by your insurance company, we are obligated to collect all co-payments, deductibles, and out-of-pocket obligations according to your insurance plan or coverage. These regulations and standards are mandated by your insurance company for us to follow. Elite Physical Therapy and Performance, PLLC works as a courtesy to verify benefits, however, as a

provider we have limited access to your information. It is for this reason that the insurance policy cardholder knows their insurance policy and coverage related to Physical Therapy Services. It is also the policy cardholder's responsibility to know how many visits your plan allows per benefit year and keep track of the number of visits utilized. You will be responsible to pay for any visits over your benefit limit.

By signing this form, I acknowledge that I understand that I am responsible for all charges not covered by my insurance coverage. This includes all copayments, deductibles, and out-of-pocket obligations.

_____ (initials)

I _____ acknowledge that I have read and reviewed the consent to treat and authorization to release information, notice of privacy practices, and patient financial obligation notice for Elite Physical Therapy and Performance, PLLC.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Patient Name: _____ Date: _____

CANCELLATIONS AND NO SHOWS

Attendance is very crucial and can be the difference between successful treatment or not. We provide scheduled time slots for each patient with a specific therapist. When you cancel or no-show without a 24 hour notice, it is very difficult to fill your spot with another patient.

Patient cancellation and no show policy:

We require **24 hours notice** in the event of a cancellation. Upon cancellation, it is required to reschedule an appointment **during the same week**, to avoid the cancellation fee.

A $20.00 cancellation fee will be applied to your account if there is less than a 24 hours notice of the cancellation and/or the appointment is not rescheduled for the same week of the missed appointment. Elite Physical Therapy and Performance, PLLC will not charge a $20.00 fee if times are unavailable for that specific week.

If you cancel **3 times** within the episode of care, you will be removed from the schedule.

If you "no show" (failure to arrive for your appointment without a cancellation call) **2 times,** you will be removed from the schedule.

I _____ acknowledge that I have read and reviewed the above cancellation and no show policy and will abide by Elite Physical Therapy and Performance, PLLC policy.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Updated: January 2023

HIPAA- MEDICAL INFORMATION RELEASE FORM

Patient Name: _____ Patient DOB: _____

Phone Number: _____ Email Address: _____

Address: _____

City/State: _____ Zip Code: _____

I hereby authorize the release of health information including but not limited to diagnosis, records, examination results, and claims information. This information my be released to:

Name	Relationship to Patient	Phone Number

ELECTRONIC TRANSMISSION

You may notify me with appointment reminders, billing statements and other information regarding my treatment as follows:

_____ Text Messages
_____ Confirmation Calls
_____ Message on Voicemail
_____ Email Address
_____ All of the Above

_____ _____
Patient Signature Date

_____ _____
Witness Date

Updated: January 2023

MEDICAL HISTORY

Patient Name: _____ DOB: _____

Reason for physical therapy: _____

Date of Injury/Onset of symptoms: _____

Height: _____ Weight: _____

Please check all the existing or relevant conditions:

☐ Allergies	☐ Anemia	☐ Anxiety
☐ Arthritis	☐ Asthma	☐ Autoimmune Disorder
☐ Cancer	☐ Cardiac Conditions	☐ Circulation Problems
☐ Currently Pregnant	☐ Depression	☐ Diabetes
☐ Dizzy Spells	☐ Fractures	☐ Gallbladder Problems
☐ Headaches	☐ Hearing Impairment	☐ High Cholesterol
☐ High/Low Blood Pressure	☐ Incontinence	☐ Kidney Problems
☐ Neurological Disorder	☐ Muscular Disease	☐ Osteoporosis
☐ Rheumatoid Arthritis	☐ Risk for Falls	☐ Vision Problems

☐ Other: _____

If "Yes" to any of the above, please explain and give approximate dates:

Surgical History:

Have you ever had any surgeries: ☐ Yes ☐ No

If "Yes" please indicate the type of surgery and the date below

Surgical Type	Surgical Date (Month/Year)

Medication History:

Are you currently taking medications: ☐ Yes ☐ No

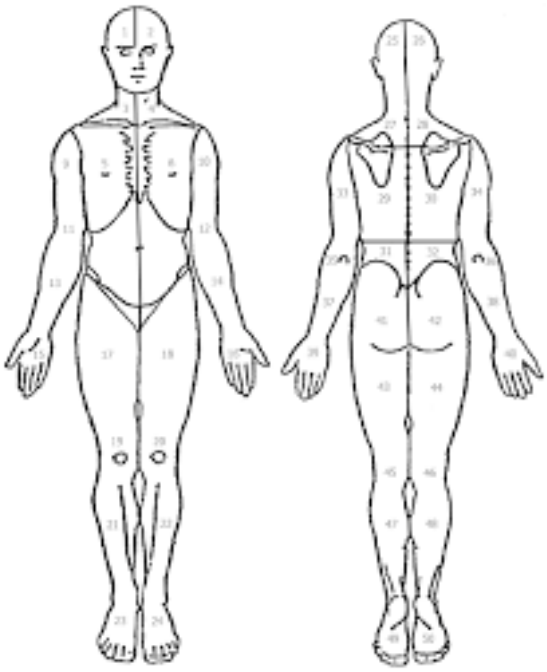
If "Yes" please indicate the name of the medication, dosage, and frequency below

Medication Type	Dosage	Frequency

Diagnostic Testing: (if applicable)

Test Type (MRI, X-ray, etc.)	Results

Pain:
Mark areas of pain on the diagram below:



I certify that the above information is true and accurate to the best of my knowledge:

_____ _____
Patient Signature Date

_____ _____
Physical Therapist Signature Date

Updated: January 2023

Elite Physical Therapy and Performance, PLLC
Address: 33487 Harper Ave. Clinton Township, MI 48035
Phone #: 586-388-0016
Email: info.elitephysicaltherapy@gmail.com

NOTICE OF PRIVACY 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.

The Health Insurance Portability and AccountabilityAct of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health case records for the purpose of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment include physical therapy.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance plan for therapy services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or main) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you.

We will use and disclose your protected health information when we are required to do so by federal, state, or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by a law enforcement official for any circumstances required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify cause of death. IF necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to

reduce or prevent a serious threat to your health and safety or health and safety of another individual or the public. Under these circumstances,we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose protected health information to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations. We may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers' compensation and similar programs. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization. You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative occasions.
- The right to access inspects and copies of your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment, and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below with the Department of Health and Human Services, Office of Civil Rights, in the event you feel you privacy rights have been violated. We will not retaliate against you for filing a complaint. For more information about our Privacy Practices, please contact:

Privacy Official:
Michael Fowler
Elite Physical Therapy and Performance, PLLC
Address
Phone #

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services OFfice of Civil Rights
200 Independence Ave, S.W.
Washington D.C. 20201
877-696-6775 (toll-free)

Updated: January 2023