REVIVE
PHYSICAL THERAPY & WELLNESS

Patient Information

First Name _____ Middle Initial ____ Last Name _____

Gender □ Female □ Male Date of Birth (mm/dd/yyyy) _____/_____/_____

Address □ Home □ Billing

Street _____ City _____

State/Province _____ Country _____ Postal Code _____

Contact

Home Phone (_____) _____ Mobile Phone (_____) _____

Email Address _____

Preferred Contact Method □ Home □ Mobile □ Email

Emergency Contact

Relationship □ Spouse □ Mother □ Father □ Sister □ Brother □ Guardian □ Other _____

Contact Name _____

Contact Phone (_____) _____

Employer Information

Employer Name _____Occupation:_____Phone (_____)_____

Provider Care Information

Referring Physician _____

Phone (_____) _____

Primary Care Physician _____

Phone (_____) _____

Body part injured _____ Surgery □ Yes □ No Date _____/_____/_____

Current Medications and/or dietary supplements_____

Past Medical History: Please list any surgeries or injuries

_____

_____

_____

_____

_____

_____

Insured Party if not Self: First Name _____ Last Name _____

Address □ Same as Above

Street _____ City _____

State/Province _____ Country _____ Postal Code _____

Gender □ Female □ Male Date of Birth (mm/dd/yyyy) _____/_____/_____

I authorize my insurance benefits to be paid directly to Achieve Therapy, LLC. I understand that I am financially responsible for any balance owed.

Signature _____ Date _____

Relationship to Patient (please specify if legal guardian, POA_____

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CONSENT FOR TREATMENT AND PAYMENT OF SERVICES

I, (print name) _____, authorize Revive Therapy, LLC to provide information regarding my illness, functional presentation, condition, and physical therapy and/or physical fitness treatments to medical practitioners, insurance carriers or any other payor to process and collect for this specific claim. I assign to Revive Therapy, LLC all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. If I am mandated to remit a co-payment per my insurance policy, I agree to render payment to Revive Therapy, LLC on day of service(s) being provided. **I understand Revive Therapy, LLC will obtain a quote of your benefit coverage as a courtesy to me and that they are, at no time, to be held responsible for incorrect information that has been provided by my insurance company. Eligibility & benefits will be determined at the time my claims are processed and I understand this is not a guarantee of payment. Benefits are subject to all contract limits and member's status on the date of service. The deductible & copayment due approximates the amount I am responsible for based on my insurance coverage and accumulated amounts, such as a deductible which may change as additional claims are processed.** If I am a private pay patient, I agree to pay **the agreed upon amount** for service(s) rendered by Revive Therapy, LLC: **$150 for the Initial Evaluation, and $100 for each additional treatment visit thereafter**. I also agree to receive treatment at revive Therapy, LLC today.

CONSENT

I consent to receive treatment from Revive Therapy, LLC. I consent to evaluation and treatment by the staff of Revive Therapy, LLC to improve any physical and/or functional impairment including but not limited to: pain, range of motion, and strength. Treatment may include but is not limited to: manual therapy, joint mobilization and/or manipulation, dry needling, supervised therapeutic exercise/therapeutic activity, strength and conditioning training, balance training, home exercise prescription and modalities. Modalities may include, but are not limited to: the use of hot packs, cold packs, therapeutic ultrasound and electrical stimulation.

RISKS

The staff of Revive Therapy, LLC will explain the potential risks, purpose, and significance of all evaluative and/or treatment techniques, including: expected outcomes/results, timeframe(s) for recovery, and potential complications and/or side effects for all therapeutic procedures. I understand and am aware there are potential risks involved with initiating a Physical Therapy program and I understand the staff of Revive Therapy, LLC will make every effort to minimize these risks by way of ongoing, thorough assessment(s) of my condition throughout the duration of my therapy program. I understand that my changing and/or improving physical condition may warrant the need for appropriate/medically necessary changes in my therapeutic treatment program.

CANCELLATION/NO-SHOW POLICY

In the event of the need for cancellation of a confirmed patient appointment with Revive Therapy, LLC, I agree to notify Revive Therapy, LLC **ONLY** by phone call within 24 hours of my scheduled appointment. I understand that my failure to abide by this policy will result in the application of a $50 cancellation/no-show fee for each missed visit, which I agree to pay prior to my next scheduled appointment. I also understand that my inability

to maintain my participation in regularly scheduled visits at Revive Therapy, LLC by way of repeatedly cancelling or not showing for scheduled appointments, may result in my discharge from services from Revive Therapy, LLC. In order to help maintain compliance with scheduled visits, I understand and agree to abide by Revive Therapy, LLC's cancellation/no-show policy.

RESPONSIBILITIES

I will inform the staff of Revive Therapy, LLC of any changes in my medical condition, medical diagnoses and/or medications as they may necessitate change to my treatment program at Revive Therapy, LLC.

I understand that an integral part of a successful therapeutic program is my participation in a Home Exercise Program by prescription and education from Revive Therapy, LLC staff. A Home Exercise Program is to be performed independently by myself outside of Revive Therapy, LLC's physical location. If I have any questions or concerns, I will direct these to the staff at the time treatment/services are being rendered. If I begin to develop any adverse symptoms during my treatment at Revive Therapy, LLC, I will inform the staff of Revive Therapy, LLC immediately. Adverse symptoms include, but are not limited to: symptoms of pain, fatigue, shortness of breath, dizziness, nausea or bowel/bladder incontinence. If I develop any adverse symptoms or new/worsening pain/symptoms during performance of my Home Exercise Program, I understand I am to cease performing this program immediately and agree to inform Revive Therapy, LLC staff at my next appointment at Revive Therapy, LLC.

I understand Revive Therapy, LLC will verify my insurance coverage for me and will notify me of co-payment, co-insurance and/or deductible amount. I understand this does not guarantee payment of services by my insurance company to Revive Therapy, LLC, and any discrepancy in coverage must be managed between myself and my insurance company.

I authorize the release of any medical information or other information necessary to process this claim.

I authorize payment of all medical benefits to Revive Therapy, LLC for services rendered and received.

SIGNATURE_____DATE_____

Best telephone number to reach you: (_____) _____

If you would like to receive appointment reminders via email: _____

If the patient being treated is under the age of 18, please have a parent or guardian sign below giving our practice consent to treat the minor named above.

Signature _____**Date**_____

NOTICE OF PRIVACY PRACTICES (HIPAA)

By signing below, I confirm the following:
I have reviewed the Notice of Privacy Practices as provided to me by Revive Therapy, LLC. I attest to my understanding of this notice, and I acknowledge understanding of how my private health information may be shared by Revive Therapy, LLC with other members of the medical and/or health/wellness/fitness communities in order to help improve my physical condition as related to the medical diagnoses and Physical Therapy assessment(s) for which I am seeking treatment at Revive Therapy, LLC.

PRINTED NAME_____

SIGNATURE_____

DATE_____

If desired, a copy can be provided: *"Yes, I would like a copy of this form."*
Copy provided by _____ (initialed by staff member)

REVIVE
PHYSICAL THERAPY & WELLNESS

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.***

YOUR RIGHTS

This section explains your rights and some of our responsibilities to help you.

You have the right to:

- Get a copy of your paper or electronic medical record
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
  - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Correct your paper or electronic medical record
  - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
  - We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communication
  - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - We will say "yes" to all reasonable requests.
- Ask us to limit the information we share
  - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- Get a list of those with whom we've shared your information
    - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
    - We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice
    - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.Choose someone to act for you
    - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
    - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you believe your privacy rights have been violated
    - You can complain if you feel we have violated your rights by contacting using the information at the bottom of this letter.
    - We will not retaliate against you for filing a complaint.
    - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/jipaa/complaints/.

YOUR CHOICES

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

You have some choices in the way that we use and share information as we:

- In these cases, you have both the right and choice to tell us to:
    - Tell family and friends about your condition
        - Share information with your family, close friends, or others involved in your care
    - Provide disaster relief
        - Share information in a disaster relief situation
    - Include you in a hospital directory
        - Include your information in a hospital directory

    If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety.

- Except as permitted or required by law, in these cases we never share your information unless you give us written permission:
    - Provide mental health care
        - Most sharing of psychotherapy notes, specialized substance abuse program records and HIV-related testing and treatment
    - Market our services and sell your information
        - Most marketing purposes
        - Sale of your information

- In the case of fundraising:
    - Raise funds
        - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES & DISCLOSURES

We typically use or share your health information in the following ways.

We may use and share your information as we:

- Treat you
    - We can use your health information and share if with other professionals who are treating you. *Example*: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization
    - We can use and share your health information to run our practice, improve your care and contact you when necessary.
      Example: We use health information about you to manage your treatment and services.
- Bill for your services
    - We can use and share your health information to bill and get payment from health plans or other entities.
      Example: We give information about you to your health insurance plan so it will pay for your services

How else can we use or share your health information? We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see www.hhs.gov/ocr/privacy/hipaa/understand/consumers/index.html.

- Help with public health and safety issues
    - We can share health information about you for certain situations such as:
        - Preventing disease
        - Helping with product recalls
        - Reporting adverse reactions to medications
        - Reporting suspected abuse, neglect or domestic violence
        - Preventing or reducing a serious threat to anyone's health or safety
- Do research
    - We can use or share your information for health research.
- Comply with the law
    - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests
    - We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
    - We can share health information with a coroner, medical examiner or funeral director when an individual dies.
- Address workers' compensation, law enforcement and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security and presidential protective services
- Respond to lawsuits and legal actions
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticeepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: August 1, 2019

Revive Therapy, LLC
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North Haven, CT 06473
Phone: 203-745-4973
Fax: 203-821-7417

This Notice of Privacy Practices applies to the following Organizations

The following covered entities are part of the Organized Health Care Arrangement. If you have a question about this Notice, would like to exercise your privacy rights, or if you feel that your privacy rights have been violated, you may contact the appropriate Organization using the information provided below: