Exercise Client Registration

The answers to the following questions are needed by your instructor to develop the best plan for you and will be held in strict confidence.

Name: _____ Sex: M F
Last First Middle Initial (circle one)

Street Address: _____City _____State_____ Zip_____

Phones: Home_____ Cell_____ Work _____

Email Address: _____

How do you prefer to be contacted regarding appointments? _____

Birthdate: _____ Age: _____

Occupation: _____ Employer Name: _____

Family Physician: _____
(Name) (Phone Number)

Emergency Contact: _____
(Name) (Phone Number) (Relationship)

How did you hear about us? (please list name so we can thank the appropriate party)
_____

What is your goal for participation in exercise at ABove PT (i.e. what would you like to work on and what benefits would you like to receive)? _____
_____
_____
_____

Please list your current physical activities: _____
_____
_____
_____

Please list any surgeries: _____
_____
_____

Please any medications or vitamins that you are currently taking:_____
_____
Please list any past or present injuries:_____
_____
_____
_____

Have you had unexplained weight loss or weight gain within the last month? Yes No

12. Do you have or have you had any of the following?

	Now	Past		Now	Past
Dizziness/ Vertigo			Diabetes		
Stroke			Arthritis		
Severe headaches			Osteoporosis		
Blurred Vision					
Double Vision			High blood pressure		
Ringing in your ears			Shortness of breath		
Nausea			Asthma		
Epilepsy			Chronic Bronchitis		
Multiple Sclerosis					
			Irregular heartbeat		
			Chest Pain		
Depression			Heart disease		
Chemical Dependency			Heart Attack		
Fever			Pacemaker		
Confusion			Congestive Heart Failure		
Pain in Calves			Peripheral Vascular Disease		
Muscle Pain			Thrombophlebitis		
Fatigue			Anemia		
Skin Disorder			Hemophilia		
Smoker How many Packs a day?____			Cancer Please list type _____		
			Thyroid problems		
Tuberculosis			Kidney/ Bladder Problems		
Hepatitis C			Liver Problems		
Acquired Immune Deficiency/ HIV			Abdominal pain/discomfort		
Hepatitis B			Ulcer/ Colitis		
			Hernia		

If your family has a history of any of the above please list:_____
_____
For females only: Are you pregnant? (circle one) Yes No Maybe

List any other information that you feel would be important for your instructor/therapist to know:_____
_____
_____
_____

I certify that the information I have provided is complete and true to the best of my knowledge.

Signature_____ Print Name_____

Date: _____

ABove **Physical Therapy Policies**

The policies of ABove Physical Therapy, LLC (ABove PT) are part of our agreement with you pertaining to your use of the ABove PT facility and equipment and your participation in any ABove PT activities or programs. Any change in these policies is at the owner's discretion and can occur at such time ABove PT sees fit. Failure to abide by these policies may result in loss of your privileges to use the facility or equipment or to participate in activities or programs and may result in loss of fees already paid. ABove PT enforces these policies using its discretion.

By Appointment Only All sessions are by appointment only. Appointments are made on a first come, first serve basis.

Early Arrival for Sessions It is important that clients arrive at least 5 minutes early for sessions. This will allow you to relax and prepare for your session. Our appointments are scheduled on the hour and arriving 5 minutes early helps to insure that you get a full session.

Hours of Operation ABove PT's hours of operation are by appointment only from Monday through Friday, with the exception of holidays and inclement weather. ABove PT may change its hours of operation as it determines necessary.

Safe Use of Equipment All equipment must be used in accordance with your instructor's instructions. At no time will a client be allowed to use the equipment at ABove PT without supervision. FAILURE TO USE EQUIPMENT AS INSTRUCTED MAY RESULT IN INJURY TO YOURSELF OR OTHERS.

Return Check Fee You will be charged $25 for any check s returned due to insufficient funds.

Return of Products All fitness products, rehabilitation products and other ABove PT products are non-exchangeable or non-refundable

Use of Cell Phones, & Pagers To be courteous of other clients, please have your cell phone & pagers in the silent or off position.

Dress Code Please dress comfortably for your sessions keeping in mind that ABove PT wishes to maintain an environment where all individuals will feel comfortable exercising and receiving therapy. If you have any questions regarding the appropriateness of attire, please do not hesitate to ask your ABove PT personnel.

Personal Belongings & Theft ABove PT provides shelves and racks for hanging and storing your belongings. Although ABove PT tries to maintain a safe environment, theft can occur anywhere. ABove PT is not responsible for any theft or your personal belongings. ABove PT recommends that you leave valuable belongings at home or locked in your car. ABove PT is not responsible for any theft in its facility, in the parking lot or surroundings.

Refusal of Service ABove PT may refuse services to anyone at anytime. If services are refused after a purchase is made, a full prorated refund will be made upon such refusal of services (unless the refusal is due

to a breach of your agreement or these policies).

Semi-private Sessions When you volunteer to be a partner with another ABove PT customer , we ask that you observe the following protocol in order to enhance the experience for you and your exercise partner:

- **Please be on time for your session** Emergencies happen, and traffic happens. But, if at all possible, please call ABove PT and your partner if you will be late. Your instructor prepares the session for both of you and if one party is repeatedly late, it disrupts the flow of the session.

- **If you must miss a session, let your partner know in advance** In the event of a no show by a partner, that partner must still pay for the session unless timely cancellation notice is received.

- **Private session in the event of cancellation** If one partner cancels a session in advance, the other partner may elect to have a private session for the scheduled period at the private session rate. **Cancellation Fee** In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that you cancel your scheduled appointment by phone or e-mail 24 hours in advance. This will allow us the opportunity to offer that appointment to another patient Cancellations must be received 24 hours prior to your scheduled session to avoid being charged for the session. This fee is not covered by insurance carriers and will be your responsibility to pay at the time of your next visit. Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated as we will be strictly enforcing this policy.

Agreement of Release and Waiver of Liability

I_____, hereby agree to the following:

1. That I am participating in the Health and Fitness Classes, Programs, Workshops, offered by ABove Physical Therapy, LLC (ABove PT) during which I will receive information and instruction about health and fitness. These exercise class may include, but are not limited to (pilates, gyrotonic, yoga, cardiovascular re-education (treadmill, elliptical, Upper Body Ergometer, and bike), Precore total gym strength training, balance training, as well as other stretching and strengthening not listed).

   I understand and recognize that physical activity, by its very nature, carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. I further acknowledge that fitness programs require physical exertion that may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved.

2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the exercise Health & Fitness Classes, Programs and Workshops offered at ABove PT. I represent and warrant that I am physically fit and I have no medical condition that would prevent my full participation in the Exercise Classes, Health Programs, or Workshops at ABove PT.

3. As I am choosing to engage in exercise of my own free will. I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in Exercise Classes, Health Programs, or Workshops at ABove PT.

4. I knowingly, voluntarily and expressly waive any claim I may have against ABove Physical Therapy, LLC for injury or damages that I may sustain as a result of participating in their Exercise Classes, Programs and Workshops.

5. I certify that I answered fully and accurately all questions regarding my General Health History and that I have disclosed all information that is material to my participation in any form of exercise at ABove PT.

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

  We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

  We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;

- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

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 actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 23, 2013and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Maria-Elena Bove for any additional questions you may have regarding you privacy rights. mariaelenabovept@gmail.com or 770-904-2332.

Above Physical Therapy Policies
I have read and received a copy of the facility policies. I understand that failure to abide by these policies my result in loss of my privilege to use the facility or the equipment or participate in activities or programs and may result in loss of fees already paid.

_____ Initials

Privacy Policy
I have been offered a Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996.

_____ Initials

Agreement of Release and Waiver of Liability
I have read and received a copy of the facility waiver. I understand the following:

- Physical Activity carries inherent risks that cannot be eliminated regardless of care taken to avoid risks.
- It is my responsibility to consult with a physician prior to and regarding my participation in exercise classes provided at the facility.
- I agree to assume full responsibility for any risks, injuries, damages, known or unknown, which might incur as result of participating in exercise classes.
- I knowingly, voluntarily, and expressly waive and claim I may have against Above Physical Therapy for injury or damages that I may sustain as a result of participating in the exercise classes.
- I certify that I answered fully and accurately all questions regarding my general health history and that I have disclosed al information that is material to my participation in any form of exercise at Above Physical Therapy.

_____ Initials

Missed Appointment Policy
Your appointment time has been reserved especially for you.

- As a courtesy, we will attempt to leave you a reminder through an automated service.
- Please call 24 hours in advance to cancel or reschedule your appointment.
- A credit card number will be necessary to hold your appointment time if you have repeatedly missed appointments without notice. **A $50.00 fee will be charged for appointments missed or canceled without 24 hour notice.**

_____ Initials

Financial Policy

Packages

We do offer packages for Pilates and Gyrotonics or you could pay-as-you-go, however, purchasing a package could save you money. Please visit our website or call our office for more information regarding pricing.

Missed Appointments

Our policy is to charge for missed appointments or for appointments not cancelled prior to 24 hour notice. **There is a $50.00 late cancellation fee**.

Returned Check Fee

There is a $15.00 fee for checks returned by the bank for non-sufficient funds.

You signature below signifies that you understand our financial policies and your responsibility regarding charges incurred in this office.

Signature_____ Print Name_____ Date_____

OR

If the participant is 18 years of age or younger:

As legal guardian of _____, I consent to the above terms and conditions.

Signature_____ Print Name_____ Date_____